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2025

Credit Transactions & Relationships
Financial Institutions
Insurance & Insurance Companies

VOLUME 6

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TITLE 31

CREDIT TRANSACTIONS AND RELATIONSHIPS

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4. Litigation Financing.

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Part 1
Loans of Money — Interest Rates

31-1-101. Loan of money — what constitutes. A loan of money is a contract by which a person delivers a sum of money to another person and the other person agrees to return at a future time a sum equivalent to that which the other person borrowed. A loan for mere use is governed by the law on loan for use.

History: **En. Sec. 2580, Civ. C. 1895; re-en. Sec. 5206, Rev. C. 1907; re-en. Sec. 7720, R.C.M. 1921; Cal. Civ. C. Sec. 1912; Field Civ. C. Sec. 966; re-en. Sec. 7720, R.C.M. 1935; R.C.M. 1947, 47-119; amd. Sec. 968, Ch. 56, L. 2009.**

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31-1-102. Loan to be repaid in current money. A borrower of money, unless there is an express contract to the contrary, must pay the amount due in such money as is current at the time when the loan becomes due, whether such money is worth more or less than the actual money lent.

History: **En. Sec. 2581, Civ. C. 1895; re-en. Sec. 5207, Rev. C. 1907; re-en. Sec. 7721, R.C.M. 1921; Cal. Civ. C. Sec. 1913; Field Civ. C. Sec. 967; re-en. Sec. 7721, R.C.M. 1935; R.C.M. 1947, 47-120.**

Cross-References

Contracts — interpretation, Title 28, ch. 2, 3.
Money defined, 30-1-201.
Money of account, Title 30, ch. 12, part 6.

31-1-103. Loan presumed to be on interest. Whenever a loan of money is made, it is presumed to be made upon interest unless it is otherwise expressly stipulated at the time in writing.

History: **En. Sec. 2582, Civ. C. 1895; re-en. Sec. 5208, Rev. C. 1907; re-en. Sec. 7722, R.C.M. 1921; Cal. Civ. C. Sec. 1914; Based on Field Civ. C. Sec. 968; re-en. Sec. 7722, R.C.M. 1935; R.C.M. 1947, 47-121.**

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Loan for exchange, Title 70, ch. 7, part 2.

31-1-104. Interest defined. Interest is the compensation allowed by law or fixed by the parties for the use or forbearance or detention of money and includes loan origination fees, points, and prepaid finance charges, as defined in 12 CFR 226.2.

History: **En. Sec. 2583, Civ. C. 1895; re-en. Sec. 5209, Rev. C. 1907; re-en. Sec. 7723, R.C.M. 1921; Cal. Civ. C. Sec. 1915; Based on Field Civ. C. Sec. 969; re-en. Sec. 7723, R.C.M. 1935; R.C.M. 1947, 47-122; amd. Sec. 1, Ch. 125, L. 2005.**

31-1-105. Annual rate. When a rate of interest is prescribed by a law or contract without specifying the period of time by which such rate is to be calculated, it is to be deemed an annual rate.

History: **En. Sec. 2584, Civ. C. 1895; re-en. Sec. 5210, Rev. C. 1907; re-en. Sec. 7724, R.C.M. 1921; Cal. Civ. C. Sec. 1916; Field Civ. C. Sec. 970; re-en. Sec. 7724, R.C.M. 1935; R.C.M. 1947, 47-123.**

31-1-106. Legal interest. (1) Except as otherwise provided by the Uniform Commercial Code, 31-1-111, and 31-1-112, unless there is an express contract in writing fixing a different rate or a law or ordinance or resolution of a public body fixing a different rate on its obligations, interest is payable on all money at the rate of 10% a year after it becomes due on:

(a) any instrument of writing, except a judgment;

(b) an account stated;

(c) money lent or due on any settlement of accounts from the date on which the balance is ascertained; and

(d) money received for the use of another person and detained from that person.

(2) In the computation of interest for a period of less than 1 year, 365 days constitute a year.

History: En. Sec. 2585, Civ. C. 1895; amd. Sec. 1, p. 125, L. 1899; re-en. Sec. 5211, Rev. C. 1907; re-en. Sec. 7725, R.C.M. 1921; Cal. Civ. C. Sec. 1917; amd. Sec. 1, Ch. 144, L. 1933; re-en. Sec. 7725, R.C.M. 1935; amd. Sec. 11-130, Ch. 264, L. 1963; amd. Sec. 38, Ch. 234, L. 1971; amd. Sec. 11, Ch. 185, L. 1977; R.C.M. 1947, 47-124; amd. Sec. 3, Ch. 275, L. 1981; amd. Sec. 1, Ch. 9, L. 1983; amd. Sec. 1, Ch. 263, L. 1985; amd. Sec. 20, Ch. 455, L. 2001; amd. Sec. 1, Ch. 278, L. 2013.

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Rate of interest on special assessments — limitations, 17-5-103.
Amount of interest on judgments, 25-9-205.
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Validity of interest rate set by contract, 27-1-213.
Acceptance of principal waives claim to interest, 27-1-214.
Offer of performance stops running of interest, 28-1-1202.

31-1-107. Interest rate allowed by agreement. (1) Parties may agree in writing to the payment of any rate of interest that does not exceed the greater of 15% or an amount that is 6 percentage points per year above the prime rate published by the federal reserve system in its statistical release H.15 Selected Interest Rates for bank prime loans dated 3 business days prior to the execution of the agreement. Interest must be allowed according to the terms of the agreement.

(2) A loan that is not usurious when made is lawful for the duration of the loan, provided the loan agreement is not substantially changed. This subsection does not apply to loan renewals.

(3) The provisions of this section do not apply to regulated lenders as defined in 31-1-111.

History: En. Sec. 2586, Civ. C. 1895; re-en. Sec. 5212, Rev. C. 1907; amd. Sec. 1, Ch. 36, L. 1913; amd. Sec. 1, Ch. 62, L. 1919; re-en. Sec. 7726, R.C.M. 1921; Cal. Civ. C. Sec. 1918; re-en. Sec. 7726, R.C.M. 1935; amd. Sec. 1, Ch. 503, L. 1975; R.C.M. 1947, 47-125; amd. Sec. 2, Ch. 373, L. 1979; amd. Sec. 4, Ch. 275, L. 1981; amd. Sec. 1, Ch. 9, L. 1983; amd. Sec. 1, Ch. 567, L. 1983; amd. Sec. 1, Ch. 588, L. 1993; amd. Sec. 2, Ch. 108, L. 2011.

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Pawnbrokers — interest, 31-1-401.
Consumer loan businesses — charges, refunds, penalties, and filing fees, 32-5-301.
Conservation practice loan program — rate set by rule, 76-15-547.
Montana agricultural loan authority — rate, 80-12-201.
Montana Facility Finance Authority — rate, 90-7-202.

31-1-108. Penalty for usury — action to recover excessive interest. (1) The taking, receiving, reserving, or charging a rate of interest greater than is allowed by 31-1-107 must be considered a forfeiture of a sum double the amount of interest that the note, bill, or other evidence of debt carries or that has been agreed to be paid on the note, bill, or other evidence of debt.

(2) When a greater rate of interest has been paid, the person by whom it has been paid or the person's heirs, assigns, executors, or administrators may recover from the person, firm, or corporation taking, receiving, reserving, or charging interest a sum double the amount of interest paid, provided that the action must be brought within 2 years after the payment of the interest, and provided that, before any suit may be brought to recover the usurious interest, the party bringing suit makes written demand for return of the interest paid.

History: En. Sec. 2, Ch. 36, L. 1913; re-en. Sec. 7727, R.C.M. 1921; re-en. Sec. 7727, R.C.M. 1935; R.C.M. 1947, 47-126; amd. Sec. 969, Ch. 56, L. 2009.

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Amount of interest on judgments, 25-9-205.
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31-1-109. When interest becomes part of principal. The parties may, in any contract in writing whereby any debt is secured to be paid, agree that, if the interest on such debt is not punctually paid, it shall become a part of the principal and thereafter bear the same rate of interest as the principal debt.

History: En. Sec. 2587, Civ. C. 1895; re-en. Sec. 5213, Rev. C. 1907; re-en. Sec. 7728, R.C.M. 1921; Cal. Civ. C. Sec. 1919; re-en. Sec. 7728, R.C.M. 1935; R.C.M. 1947, 47-127.

Cross-References

Amount of interest on judgment, 25-9-205.
Written contracts, Title 28, ch. 2, part 9.

31-1-110. Renumbered 25-9-205. Code Commissioner, 1979.

31-1-111. Definition of regulated lender. The term "regulated lender", as used in 31-1-112 and 31-1-116, means:

(1) a bank, building and loan association, savings and loan association, trust company, credit union, credit association, consumer loan licensee, deferred deposit loan licensee, residential mortgage lender licensee, development corporation, bank holding company, or mutual or stock insurance company organized pursuant to state or federal statutory authority and subject to supervision, control, or regulation by:

(a) an agency of the state of Montana; or

(b) an agency of the federal government;

(2) a subsidiary of an entity described in subsection (1);

(3) a Montana state agency or a federal agency that is authorized to lend money;

(4) a corporation or other entity established by congress or the state of Montana that is owned, in whole or in part, by the United States or the state of Montana and that is authorized to lend money.

History: En. Sec. 1, Ch. 275, L. 1981; amd. Sec. 1, Ch. 9, L. 1983; amd. Sec. 1, Ch. 406, L. 1985; amd. Sec. 1, Ch. 294, L. 1991; amd. Sec. 2, Ch. 140, L. 2001; amd. Sec. 33, Ch. 369, L. 2007; amd. Sec. 1, Ch. 451, L. 2007; amd. Sec. 1, Ch. 497, L. 2007; amd. Sec. 2, Ch. 278, L. 2013.

Cross-References

Banks and trust companies, Title 32, ch. 1.
Mutual savings and loan associations, Title 32, ch. 2.
Credit unions, Title 32, ch. 3.
Development corporations, Title 32, ch. 4.
Consumer loan businesses, Title 32, ch. 5.

31-1-112. Interest rate limitation exemption — regulated lenders — merchant finance. (1) A regulated lender, except for a deferred deposit loan licensee or consumer loan licensee, is exempt from all limitations on the rate of interest that it may charge and is exempt from the operation and effect of all usury statutes.

(2) A finance operation that finances transactions between merchants, as defined in 30-2-104, is also exempt from usury limits.

History: (1)En. Sec. 2, Ch. 275, L. 1981; (2)En. Sec. 4, Ch. 276, L. 1981; amd. Sec. 1, Ch. 9, L. 1983; amd. Sec. 1, Ch. 22, L. 1983; amd. Sec. 2, I.M. No. 164, approved Nov. 2, 2010; amd. Sec. 3, Ch. 278, L. 2013.

31-1-113. Limitation of rule of 78ths. The sum of the monthly time balances method of computing interest or refunds on prepayment, which is also known as the rule of 78ths, may not be used in any loan agreement or retail installment contract unless the term of the loan or contract does not exceed 61 months.

History: En. Sec. 3, Ch. 135, L. 1983.

Cross-References

Requirements of retail installment contracts, 31-1-231.
Refunds on prepayment, 31-1-242.
Consumer loan businesses — charges, refunds, penalties and filing fees, 32-5-301.

31-1-114 reserved.

31-1-115. Issuing credit cards to minors — collection of debt. (1) An issuer of a credit card or similar loan advance access device may not issue a credit card or similar loan advance access device to a minor, as defined in 41-1-101, residing in this state without first obtaining consent to the issuance from the minor's parent or legal guardian.

(2) An issuer of a credit card or similar loan advance access device that does not receive a parent's or legal guardian's consent, as required in subsection (1), before issuing the credit card or similar loan advance access device to a minor may not collect in this state from the minor or the minor's parent or guardian any debt incurred by the minor through the use of the credit card or similar loan advance access device.

History: En. Sec. 1, Ch. 21, L. 1997.

31-1-116. Commercial loans — when written agreement required. (1) With respect to a commercial loan, a contract action or a breach of contract action may not be brought against a regulated lender on a promise or commitment that is not in writing where the promise or commitment is to:

(a) lend money or to extend credit;

(b) alter, amend, renew, extend, or otherwise modify an existing promise, commitment, or agreement to lend money or extend credit; or

(c) make a financial accommodation.

(2) For the purposes of this section, "commercial loan" means money loaned or credit extended primarily for commercial or business purposes, in excess of $100,000, and does not include money lent or credit extended for personal, family, or household purposes and also does not include charge or credit card accounts, personal lines of credit, personal overdraft accounts, or other consumer accounts.

History: En. Sec. 1, Ch. 140, L. 2001.

Part 2
Retail Installment Sales

Part Cross-References

U.C.C. — sales, Title 30, ch. 2.
Sales, Title 30, ch. 11.
Personal solicitation sales, Title 30, ch. 14, part 5.
Montana Consumer Loan Act, Title 32, ch. 5.
Loans for use, Title 70, ch. 7, part 1.

31-1-201. Short title. This part may be cited as the "Montana Retail Installment Sales Act".

History: En. Sec. 1, Ch. 282, L. 1959; R.C.M. 1947, 74-601.

31-1-202. Definitions — scope. (1) Unless the context requires otherwise, in this part, the following definitions apply:

(a) "Cash sale price" means the price stated in a retail installment contract or in a sales slip or other memorandum furnished by a retail seller to a retail buyer under or in connection with a retail charge account agreement for which the seller would have sold or furnished to the buyer and the buyer would have bought or obtained from the seller the goods or services that are the subject matter of the retail installment transaction, if the sale had been a sale for cash. The cash sale price may include any taxes, registration, certificate of title, license, and official fees and cash sale prices for services, if any, and for accessories and their installation and for delivering, servicing, repairing, or improving the goods.

(b) "Conspicuous" means that:

(i) a heading is in capital letters equal to or greater in size than the surrounding text or in contrasting type, font, or color than the surrounding text of the same or lesser size; or

(ii) language in the body of a record or display is in larger type than the surrounding text, is in contrasting type, font, or color than the surrounding text of the same size, or is set off from the surrounding text of the same size by symbols or other marks that call attention to the language.

(c) "Department" means the department of administration provided for in Title 2, chapter 15, part 10.

(d) "Finance charge" means the amount, as limited by 31-1-241, in addition to the principal balance, agreed upon between the buyer and the seller, to be paid by the buyer for the privilege of purchasing goods or services to be paid for by the buyer in one or more deferred installments.

(e) "Goods" means all chattels personal, including motor vehicles and merchandise certificates or coupons exchangeable for chattels personal but not including money, things in action, or dwellings as defined in 15 U.S.C. 1602(w).

(f) "Holder" means:

(i) the retail seller of the goods or services under the retail installment contract or retail charge account agreement or a person who establishes and administers retail charge account agreements with retail buyers;

(ii) the assignee, if the retail installment contract or the retail charge account agreement or the balance in the account under either has been sold or otherwise transferred; or

(iii) any other person entitled to the rights of the retail seller under any retail installment contract or any retail charge account agreement.

(g) "Manufactured structure" means any structure, transportable in one or more sections, designed to be used as a single-family dwelling or commercial building with or without a permanent foundation when connected to the required utilities and includes the plumbing, heating, air-conditioning, and electrical systems contained in the structure.

(h) (i) "Motor vehicle" means any new or used automobile, motorcycle, quadricycle, truck, trailer, semitrailer, truck tractor, and all vehicles with any power, other than muscular power, primarily designed or used to transport persons or property on a public highway.

(ii) The term does not include any vehicle that runs only on rails or tracks or in the air.

(iii) The term does not include a dwelling as defined in 15 U.S.C. 1602(w).

(i) "Official fees" means:

(i) the fees prescribed by law for filing, recording, or otherwise perfecting and releasing or satisfying any title or lien retained or taken by a seller in connection with a retail installment transaction; or

(ii) the premium for insurance in lieu of filing, recording, or otherwise perfecting any title or lien retained or taken by a seller in connection with a retail installment transaction to the extent that the premium does not exceed the fees that would otherwise be payable for filing, recording, or otherwise perfecting and releasing or satisfying any title or lien retained or taken by a seller in connection with a retail installment transaction.

(j) "Person" means an individual, partnership, corporation, association, and any other group, however organized.

(k) "Principal balance" means the cash sale price of the goods or services that are the subject matter of a retail installment transaction plus the amounts, if any, included in the sale, if a separate identified charge is made and stated in the contract, for insurance and other benefits and official fees, minus the amount of the buyer's downpayment in money or goods.

(l) "Recreational vehicle" means a vehicular type unit that either has its own motor power or is mounted on or drawn by another vehicle and that is primarily designed as temporary living quarters for recreational, camping, or travel use.

(m) "Retail buyer" or "buyer" means a person who buys goods or obtains services from a retail seller in a retail installment transaction and not for the purpose of resale.

(n) "Retail charge account agreement" means an instrument in writing prescribing the terms of retail installment transactions that may be made under it from time to time under which a retail seller gives to a retail buyer the privilege of using a credit card issued by the retail seller or any other person or other credit confirmation or identification for the purpose of purchasing goods or services from the retail seller, from the retail seller and any other person, or from a person licensed or franchised by the retail seller and under the terms of which a finance charge may be computed in relation to the buyer's average daily balance in the account during the billing cycle or the buyer's balance from time to time.

(o) "Retail installment contract" or "contract" means an agreement evidencing a retail installment transaction entered into in this state under which a buyer promises to pay in one or more deferred installments the time sale price of goods or services, or both. The term includes a chattel mortgage, a conditional sales contract, and a contract for the bailment or leasing of goods by which the bailee or lessee contracts to pay as compensation for its use a sum substantially equivalent to or in excess of its value and by which it is agreed that the bailee or lessee is bound to become, or for no further or a merely nominal consideration has the option of becoming, the owner of the goods upon full compliance with the provisions of the contract.

(p) "Retail installment transaction" means a written contract to sell or furnish, or the sale or furnishing of, goods or services by a retail seller to a retail buyer pursuant to a retail charge account agreement or under a retail installment contract.

(q) "Retail seller" or "seller" means a person who sells goods or furnishes services to a retail buyer in a written retail installment contract or written retail installment transaction.

(r) (i) "Sales finance company" means a person engaged, in whole or in part, in the business of purchasing retail installment contracts from one or more sellers. The term includes but is not limited to a bank, trust company, investment company, credit union, or savings and loan association, if engaged in purchasing retail installment contracts.

(ii) The term does not include a person who makes only isolated purchases of retail installment contracts that are not being made in the course of repeated and successive purchases of retail installment contracts from the same seller.

(s) "Services" means work, labor, and services furnished in the delivery, installation, servicing, repair, or improvement of goods.

(t) "Time sale price" means the total of the cash sale price of the goods or services and the amount, if any, included for insurance and other benefits, if a separate identified charge is made for insurance and benefits, and the amounts of the official fees and the finance charge.

(2) (a) This part does not apply to the lending of money by banks or other lending institutions and securing loans by chattel mortgages of goods in the ordinary course of lending by those banks or other lending institutions.

(b) This part applies to the extension of credit by those banks or other lending institutions under retail installment contracts or credit cards issued by those banks or other lending institutions.

(c) This part does not apply to a transaction governed by Title 32, chapter 9, part 1.

History: En. Sec. 2, Ch. 282, L. 1959; amd. Sec. 1, Ch. 416, L. 1971; amd. Sec. 137, Ch. 431, L. 1975; R.C.M. 1947, 74-602; amd. Sec. 1, Ch. 160, L. 1979; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 13, Ch. 516, L. 1985; amd. Sec. 1, Ch. 297, L. 1987; amd. Sec. 1, Ch. 198, L. 1993; amd. Sec. 70, Ch. 483, L. 2001; amd. Sec. 1, Ch. 317, L. 2011; amd. Sec. 1, Ch. 63, L. 2013; amd. Sec. 16, Ch. 123, L. 2013.

Cross-References

Fees of Clerk of District Court, 25-1-201.
Contract defined, 28-2-101.
U.C.C. — buyer in ordinary course of business and holder defined, 30-1-201.
U.C.C. — goods defined, 30-2-105.
U.C.C. — sale defined, 30-2-106.
U.C.C. — negotiable instruments — rights of holder, Title 30, ch. 3, part 3.
Camper defined, 61-1-101.
Motorcycle defined, 61-1-101.
Motor vehicle defined, 61-1-101.
Quadricycle defined, 61-1-101.
Recreational vehicle defined, 61-1-101.

31-1-203. Notice and opportunity for hearing — service — penalties — exception. (1) The department shall provide a 14-day written notice of alleged violations of this part and opportunity for an administrative hearing under the Montana Administrative Procedure Act. The notice must be based on reasonable cause to believe that a licensee or any person, whether licensed or not, has:

(a) violated any of the provisions of this part;

(b) failed to comply with the rules or orders promulgated by the department;

(c) furnished false information to the department; or

(d) operated without a required license.

(2) The department may impose a civil penalty not to exceed $1,000 for each violation and may require restitution to buyers and reimbursement of the department's costs in bringing an administrative action.

(3) The department may suspend, revoke, or condition the license of a person violating this part. The suspension, revocation, or conditioning of a license does not affect the rights and obligations of the parties to retail installment contracts acquired previously by the licensee. If a licensee is a legal entity, it is sufficient cause for the suspension, revocation, or conditioning of a

license that any officer, director, or trustee of a licensed association or corporation, any member or manager of a licensed limited liability company, or any partner of a licensed partnership has acted or failed to act so as to provide cause for suspending, revoking, or conditioning a license. Each licensee is responsible for the acts of the licensee's employees and agents acting within the course and scope of their employment or agency relationship with the licensee.

(4) In addition to other penalties provided by law, any person violating 31-1-231 through 31-1-243, except as the result of an isolated accidental and bona fide error of computation, is barred from recovery of any finance, delinquency, or collection charge on the contract. A person violating 31-1-231 through 31-1-243 as a result of an isolated accidental and bona fide error of computation may not recover or retain any overcharge resulting from the error.

(5) In addition to other penalties provided by law, a violation of this part and a contract made in violation of the finance charge limitations imposed by 31-1-241 is a violation of Title 30, chapter 14, part 1.

(6) All notices, hearing schedules, and orders must be mailed by certified mail to the licensee's Montana address of record with the department or in the case of an unlicensed person to the last address known to the department. For licensees authorized to do business in this state and having no physical business location or address in this state, service of process must be made by certified mail upon the licensee's registered agent of record with the secretary of state, and subsequent hearing schedules and orders must be mailed by certified mail to the licensee's out-of-state address of record with the department.

History: **En. Sec. 11, Ch. 282, L. 1959; amd. Sec. 16, Ch. 185, L. 1977; amd. Sec. 3, Ch. 284, L. 1977; R.C.M. 1947, 74-611; amd. Sec. 3, I.M. No. 164, approved Nov. 2, 2010; amd. Sec. 2, Ch. 63, L. 2013.**

Cross-References

Actions to enforce penalty or forfeiture or other statutory liability, 27-2-211.
Misdemeanor defined, 45-2-101.

31-1-204. Waiver. Any waiver of the provisions of this part shall be unenforceable and void.

History: **En. Sec. 12, Ch. 282, L. 1959; R.C.M. 1947, 74-612.**

Cross-References

Contracts that violate policy of law — exemption from responsibility, 28-2-702.

31-1-205 through 31-1-210 reserved.

31-1-211. Powers of department. (1) The department may adopt rules necessary to carry out the intent and purposes of this part.

(2) The department may issue subpoenas to compel the attendance of witnesses and the production of documents, papers, books, records, and other evidence before it in any matter over which it has jurisdiction, control, or supervision pertaining to this part. The department may administer oaths and affirmations to a person whose testimony is required.

(3) If a person refuses to obey a subpoena or to give testimony or produce evidence as required by it, a judge of the district court of the county in which the licensed premises are located may, upon application and proof of the refusal, issue a subpoena or subpoena duces tecum for the witness to appear before the department to give testimony and produce evidence as may be required. The clerk of court shall then issue the subpoena, as directed, under the seal of the court, requiring the person to whom it is directed to appear at the time and place designated in it.

(4) If a person served with a subpoena refuses to obey it or to give testimony or produce evidence as required by the subpoena, the department may apply to the judge of the court issuing the subpoena for an arrest warrant for that person, as for a contempt. The judge, upon satisfactory proof of the refusal, shall issue an arrest warrant, directed to any sheriff, constable, or police officer, for the arrest of that person and, upon that person being brought before the judge, proceed to a hearing of the case. The judge may compel:

(a) obedience to the subpoena;
(b) the answering of any question;
(c) the production of any evidence that may be proper; or
(d) the witness to pay the costs of the proceeding.

(5) Failure to comply with the requirements of subsection (4)(a), (4)(b), or (4)(c) is punishable by a fine not exceeding $100 or by imprisonment in the county jail, or both.

History: En. Sec. 6, Ch. 282, L. 1959; amd. Sec. 140, Ch. 431, L. 1975; amd. Sec. 15, Ch. 185, L. 1977; R.C.M. 1947, 74-606; amd. Sec. 1, Ch. 265, L. 1995; amd. Sec. 3, Ch. 63, L. 2013.

Cross-References

Oaths, Title 1, ch. 6, part 1.
Adoption and publication of rules, Title 2, ch. 4, part 3.
Contempts, Title 3, ch. 1, part 5.
Department of Administration authority, 30-14-114.
Investigations, 30-14-221.
Banks — examination and supervision by Department of Administration, 32-1-211.
Examinations, 32-3-203.
Access to records — witnesses, 32-5-404.
Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.
Entry, inspection, and investigation of milk production facilities and records, 81-23-401.

31-1-212. Investigations and complaints. (1) The department may make those investigations it considers necessary, and to the extent necessary for this purpose, it may examine a licensee or any other person and may compel the production of relevant books, records, accounts, and documents.

(2) A retail buyer having reason to believe that this part relating to the buyer's retail installment contract has been violated may file with the department a written complaint setting forth the details of the alleged violation, and the department, upon receipt of the complaint, may inspect the pertinent books, records, letters, and contracts of the licensee and retail seller involved.

History: En. Sec. 5, Ch. 282, L. 1959; amd. Sec. 139, Ch. 431, L. 1975; R.C.M. 1947, 74-605; amd. Sec. 970, Ch. 56, L. 2009.

Cross-References

Consumer protection — Department of Administration investigations, 30-14-221.
Discrimination in credit transactions, 49-2-403.

31-1-213 through 31-1-220 reserved.

31-1-221. Licensing of sales finance companies required. (1) A person may not engage in the business of a sales finance company, including the purchase of retail installment contracts that are entered into in this state, without a license as provided in this part, except that a bank, trust company, savings and loan association, or credit union authorized to do business in this state is not required to obtain a license under this part but shall comply with all of the other provisions of this part.

(2) The application for a license must be in writing in the form and submitted in the manner that the department may direct.

(3) The license fee for each calendar year or part of a year is $100 for the applicant's principal place of business and for each additional branch location at which the applicant engages in sales finance company activities concerning retail installment contracts between retail sellers and buyers in this state. A licensee need not maintain a physical place of business within this state.

(4) Except as provided in 31-1-222, upon the submission of a complete license application and the payment of required fees, the department shall issue a license to the applicant to engage in the business of a sales finance company in accordance with the provisions of this part for a period that expires December 31 following the date of the license's issuance. The license is not transferable or assignable. A licensee may not transact any business provided for by this part under any other name.

(5) The department may direct that fees chargeable under subsection (3) be remitted to the department through a nationwide licensing system. The department's portion of fees charged and collected under this chapter must be deposited in the state special revenue fund for the use of the department in its supervision function.

History: En. Sec. 3, Ch. 282, L. 1959; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 74-603; amd. Sec. 8, Ch. 600, L. 1985; amd. Sec. 1, Ch. 9, L. 2003; amd. Sec. 4, Ch. 63, L. 2013.

Cross-References

Fund structure, 17-2-102.
Consumer loan businesses — licensure requirements, Title 32, ch. 5, part 2.

31-1-222. Denial of licenses. Subject to the notice and opportunity for hearing provisions of 31-1-203, initial licensure or license renewal may be denied by the department on the following grounds:

(1) material misstatement of fact or material omission of fact in the application for license or renewal;

(2) a civil judgment against the applicant for defrauding a retail buyer in relation to financing terms of a retail installment contract; or

(3) having had a sales finance company license or other financial services license revoked by a regulatory agency in any jurisdiction.

History: En. Sec. 4, Ch. 282, L. 1959; amd. Sec. 138, Ch. 431, L. 1975; amd. Sec. 14, Ch. 185, L. 1977; R.C.M. 1947, 74-604; amd. Sec. 971, Ch. 56, L. 2009; amd. Sec. 5, Ch. 63, L. 2013.

Cross-References

Contractual provisions relating to fraud, 28-2-404 through 28-2-406.

Principal's responsibility for agent's negligence, omissions, and wrongs, 28-10-602.

Department of Administration to restrain unlawful acts, 30-14-111.

Consumer loan businesses — notice of violation — administrative hearing — penalties — liability, 32-5-207.

Unsworn falsification to authorities, 45-7-203.

31-1-223. Department authorized to participate in nationwide licensing system for purposes of licensing sales finance companies — rulemaking. (1) The department is authorized to participate in a nationwide licensing system for licensing purposes under this part and may require sales finance companies to apply for licensure in the manner and form that the department may direct.

(2) The department may establish requirements through rulemaking as necessary to comply with the protocols and procedures of a nationwide licensing system pertaining to fees, renewal dates, amending or surrendering a license, and any other activity necessary for participation in the nationwide licensing system.

(3) The department's portion of the licensing fees collected under this part must be deposited into the department's account in the state special revenue fund to be used for administering this part.

History: En. Sec. 12, Ch. 63, L. 2013.

Cross-References

Department authorized to participate in nationwide licensing system for purposes of licensing deferred deposit loan licensees — rulemaking, 31-1-710.

Department authorized to participate in nationwide licensing system for purposes of licensing consumer loan licensees — rulemaking, 32-5-209.

Department authority to utilize nationwide licensing system for licensing escrow businesses, 32-7-112.

31-1-224 through 31-1-230 reserved.

31-1-231. Requirements of retail installment contracts. (1) Each retail installment contract must be in writing, signed by both the buyer and the seller, and completed as to all essential provisions prior to the signing of the contract by the buyer. However, if a retail installment transaction is a sale of goods other than a motor vehicle where title, lien, or other security interest is not retained or taken by the seller, then the retail installment contract is not required to be contained in a single document. In that case, if the contract is contained in more than one document, then one document may be an original document executed by the retail buyer applicable to purchases of goods or services to be made by the retail buyer from time to time, and in that case the document, together with the sales slip, account book, or other written statement relating to each purchase, must set forth all of the information required by this section and constitutes the retail installment contract for each purchase.

(2) The printed portion of the contract, other than instructions for completion, must be in at least 8-point type. The contract must conspicuously disclose the following notice:

"1. Notice to the buyer. Do not sign this contract before you read it or if it contains any blank spaces other than blank spaces for the serial number of the goods or other similar information and the due date of the first installment if the goods have not been delivered to you at the time you sign the contract.

2. You are entitled to an exact copy of the contract bearing your signature.

3. Under the law, you have the right to pay off in advance the full amount due and to obtain a partial refund of the finance charge."

(3) If the contract covers the sale of a motor vehicle, it must also contain a specific statement that is conspicuously disclosed that liability insurance coverage for bodily injury and property damage caused to others is not included if that is the case.

(4) The contract must contain the names of the seller and the buyer, the place of business of the seller, the residence or place of business of the buyer as specified by the buyer, and a description of the goods sold or services furnished or to be furnished and must clearly state and describe any collateral security taken for the buyer's obligation.

(5) The contract must contain the following items:

(a) the cash sale price of the goods or services;

(b) the amount of the buyer's downpayment and whether made in money or goods or partly in money and partly in goods, including a brief description of the goods traded in;

(c) the difference between items in subsections (5)(a) and (5)(b);

(d) the amount, if any, included for insurance and other benefits if a separate charge is made for insurance and other benefits, specifying the types of coverage and benefits;

(e) the amount of official fees;

(f) the principal balance, which is the sum of items in subsections (5)(c) through (5)(e);

(g) the amount of the finance charge;

(h) the total amount of the time balance, stated as one sum in dollars and cents, which is the sum of items in subsections (5)(f) and (5)(g), payable in installments by the buyer to the seller;

(i) the number of installments;

(j) the amount of each installment; and

(k) the due date or period of installments.

(6) The items in subsection (5) need not be stated in the sequence or order set forth, and additional items may be included to explain the computations made in determining the amount to be paid by the buyer.

(7) A retail installment contract may not be signed by any party when it contains blank spaces to be filled in after it has been signed, except that if delivery of the goods is not made at the time of the signing of the contract, the serial number of the goods or similar information and the due date of the first installment may be inserted in the contract after it is signed. The buyer's written acknowledgment, conforming to the requirements of 31-1-232, of delivery of a copy of a contract, in any action or proceeding by or against a holder of the contract without knowledge to the contrary when the holder purchases the contract, must be conclusive proof:

(a) of the delivery;

(b) that the contract when signed did not contain any blank spaces except as provided in this subsection (7); and

(c) of compliance with 31-1-231 through 31-1-236.

(8) If a retail installment transaction is subject to the federal Truth in Lending Act, 15 U.S.C. 1601-1667e, a seller that has complied with all of the requirements of the act must be considered to have satisfied the requirements of subsections (2) through (6) of this section.

(9) A person may not engage in any device or subterfuge intended to evade the requirements of this part, including making loans or assisting another in making loans disguised as personal property sales and leaseback transactions or disguising or assisting another in disguising loan proceeds as cash rebates for the pretextual installment sale of goods or services.

History: En. Sec. 7, Ch. 282, L. 1959; R.C.M. 1947, 74-607(part); amd. Sec. 1, Ch. 88, L. 1979; amd. Sec. 1, Ch. 89, L. 1985; amd. Sec. 972, Ch. 56, L. 2009; amd. Sec. 6, Ch. 63, L. 2013.

Cross-References

What contracts must be in writing, 28-2-903.

Consumer loan businesses — installment payment — contract period, 32-5-302.

Borrower to receive copy of contract or statement of contents, 32-5-303.

Motor vehicles — certain financing agreements prohibited, 61-4-403.

31-1-232. Buyer's right of rescission. The seller shall deliver to the buyer in person or mail to the buyer at the address shown in the contract a copy of the contract, signed by the seller. If the contract is mailed, the seller shall retain proof of delivery. Until the seller delivers or mails the contract, a buyer who has not received delivery of the goods or been furnished the services has the right to rescind the agreement and to receive a refund of all payments made and return of all goods traded in to the seller on account of or in contemplation of the contract or, if the goods cannot be returned, the value of the goods. Any acknowledgment by the buyer of personal delivery of a copy of the contract signed by the seller must be conspicuous and, if contained in the contract, must appear directly above the buyer's signature.

History: **En. Sec. 7, Ch. 282, L. 1959; R.C.M. 1947, 74-607(part); amd. Sec. 973, Ch. 56, L. 2009; amd. Sec. 7, Ch. 63, L. 2013.**

Cross-References

Extinction of contracts — rescission, Title 28, ch. 2, part 17.
U.C.C. — sales — manner and effect of rightful rejection, 30-2-602.

31-1-233. Insurance. (1) The amount, if any, included for insurance that may be purchased by the holder of the contract may not exceed the applicable premiums chargeable in accordance with the rates filed with the insurance department of this state when the rates are required by law to be approved by the insurance department.

(2) All insurance purchased by the holder of the contract must be written by an insurance company authorized to do business in this state.

(3) A buyer may be required to provide insurance on the goods at the buyer's own cost for the protection of the seller or holder as well as the buyer, but the insurance is limited to insurance against substantial risk of loss, damage, or destruction of the goods.

(4) Any other insurance may be included in a retail installment transaction at the buyer's expense only if contracted for voluntarily by the buyer.

(5) If insurance for which an identified charge is made insures the life, safety, or health of the buyer or the buyer's interest in goods and is purchased by the holder, the holder shall within 30 days after the execution of the retail installment contract send or cause to be sent to the buyer a policy or policies or certificate or certificates of insurance, written by an insurance company authorized to do business in this state, clearly setting forth:

(a) the amount of the premium;

(b) the kind or kinds of insurance;

(c) the coverages; and

(d) if a policy, all the terms, exceptions, limitations, restrictions, and conditions of the contract or contracts of insurance or, if a certificate, a summary of the terms, exceptions, limitations, restrictions, and conditions.

(6) The holder may not decline existing insurance written by an insurance company authorized to do business in this state, and the buyer has the privilege of purchasing insurance from an insurance producer or broker of the buyer's own selection and of selecting the buyer's insurance company if:

(a) the insurance company is acceptable to the holder, which acceptance may not be unreasonably or arbitrarily withheld; and

(b) the inclusion of the cost of the insurance premium in the retail installment contract when the buyer selects the buyer's insurance producer, broker, or company is optional with the holder.

(7) If any insurance is canceled or the premium adjusted, any refund of the insurance premium received by the holder must be credited to the final maturing installment of the contract except to the extent applied toward payment for a similar insurance protecting the interests of the buyer and the holder or either of them.

History: **En. Sec. 7, Ch. 282, L. 1959; R.C.M. 1947, 74-607(part); amd. Sec. 34, Ch. 16, L. 1991; amd. Sec. 9, Ch. 472, L. 1999.**

Cross-References

U.C.C. — sales — insurable interest in goods — manner of identification of goods, 30-2-501.
Consumer loan businesses — insurance, 32-5-306.
Insurance — compliance with Code required, 33-1-102.
Commissioner of Insurance — general powers and duties, 33-1-311.

31-1-234. Transfer of equity — fee. A buyer may transfer the buyer's equity in the goods at any time to another person upon agreement by the holder, but the holder of the contract is entitled to a transfer of equity fee that may not exceed $50.

History: **En. Sec. 7, Ch. 282, L. 1959; R.C.M. 1947, 74-607(part); amd. Sec. 1, Ch. 434, L. 1983; amd. Sec. 974, Ch. 56, L. 2009.**

Cross-References

Transfer of rights and duties under obligation, Title 28, ch. 1, part 10.
Assignment of nonnegotiable written contract, 28-2-206.
U.C.C. — sales — delegation of performance — assignment of rights, 30-2-210.

31-1-235. Delinquency fee. (1) The holder of a retail installment contract or a retail charge account agreement may collect a delinquency charge on each installment in default for a period not less than 10 days in an amount not to exceed $10 or, alternatively, the holder may calculate a fixed delinquency fee that is expressed as an interest rate not exceeding 15% of each installment in default. The delinquency charge expressed in this subsection as a simple interest rate represents a method of calculating a fixed delinquency charge and is not interest.

(2) This section does not preclude a holder of a retail installment contract or retail charge account agreement from collecting, in addition to the delinquency charge, regularly accruing interest at the current contract rate applicable under the terms of the buyer's and seller's contract, provided the contract was made on simple interest and is not a precomputed contract.

(3) A retail installment contract may provide for the payment of both a delinquency charge as permitted in subsection (1) and attorney fees not exceeding 15% of the amount due and payable under the contract when the contract is referred for collection to an attorney not a salaried employee of the holder of the contract and for court costs and actual and reasonable out-of-pocket expenses incurred in connection with the delinquency.

History: **En. Sec. 7, Ch. 282, L. 1959; R.C.M. 1947, 74-607(part); amd. Sec. 2, Ch. 198, L. 1993; amd. Sec. 1, Ch. 266, L. 1997; amd. Sec. 8, Ch. 63, L. 2013.**

Cross-References

Allowable costs, Title 25, ch. 10, part 2.

Attorney fees, Title 25, ch. 10, part 3.

Contractual right to attorney fees treated as reciprocal, 28-3-704.

Consumer loan businesses — deferral charge permitted — nature of deferral charge, 32-5-321.

31-1-236. Notice and receipt of payment. (1) Upon written request from the buyer, the holder of a retail installment contract shall give or forward to the buyer a written statement of the dates and amounts of payments and the total amount unpaid under the contract. A buyer must be given a written receipt for any payment when made in cash.

(2) After payment of all sums for which the buyer is obligated under a contract, the holder shall deliver or mail to the buyer, at the buyer's last-known address, one or more good and sufficient instruments to acknowledge payment in full and shall release all security in the goods or in any collateral security.

History: **En. Sec. 7, Ch. 282, L. 1959; R.C.M. 1947, 74-607(part); amd. Sec. 975, Ch. 56, L. 2009; amd. Sec. 9, Ch. 63, L. 2013.**

Cross-References

Consumer loan businesses — receipts — return of note, 32-5-304.

31-1-237 through 31-1-240 reserved.

31-1-241. Finance charge limitation. (1) The finance charge included in a retail installment contract must be at a rate agreed upon by the retail seller and the buyer, but the finance charge may not exceed 36% per annum.

(2) The finance charge included in a retail charge account agreement must be at a rate agreed upon by the retail seller and the buyer, but the finance charge may not exceed 36% per annum.

(3) The finance charge must be computed from month to month (which need not be a calendar month) or over another regular billing cycle period by using either:

(a) the average daily balance in the account in the billing cycle period; or

(b) the ending balance of the account as of the last day of the billing cycle period less the amount of total purchases charged to the account during that billing cycle.

(4) A seller may change the terms of a revolving charge account whether or not the change is authorized by prior agreement. The seller shall give the buyer written notice of any change at least 45 days before the effective date of the change.

(5) If the retail seller increases the finance charge on a retail charge account agreement, then the increased rate may only be applied to the balance consisting of purchases on other charges incurred on or after the effective date of the increase.

(6) For purposes of determining the balance to which the increased rate applies, all payments may be considered to be applied to the balance existing prior to the change in rate until that balance is paid in full.

(7) If the finance charge determined pursuant to subsection (3) for a monthly period is less than 50 cents, a maximum finance charge not in excess of 50 cents may be charged and collected for the period.

History: **En. Sec. 8, Ch. 282, L. 1959; amd. Sec. 11-152, Ch. 264, L. 1963; amd. Sec. 2, Ch. 416, L. 1971; amd. Sec. 1, Ch. 252, L. 1975; amd. Sec. 1, Ch. 284, L. 1977; R.C.M. 1947, 74-608; amd. Sec. 2, Ch. 160, L. 1979; amd. Secs. 1, 2, Ch. 276, L. 1981; amd. Secs. 1, 3, Ch. 22, L. 1983; amd. Sec. 2, Ch. 297, L. 1987; amd. Sec. 1, Ch. 267, L. 1997; amd. Sec. 4, I.M. No. 164, approved Nov. 2, 2010; amd. Sec. 10, Ch. 63, L. 2013.**

Cross-References

Interest defined, 31-1-104.
Legal interest, 31-1-106.
Interest rate allowed by agreement, 31-1-107.
Limitation of Rule of 78ths, 31-1-113.
Consumer loan businesses — charges, refunds, penalties, and filing fees, 32-5-301.

31-1-242. Refunds on prepayment. Notwithstanding any other provision of law or terms of any retail installment contract to the contrary, any buyer may prepay in full, at any time before maturity, the debt of any retail installment contract and upon paying the debt must receive a refund credit for the anticipation of payments on a precomputed contract or for any other unearned fees calculated by use of the actuarial method. The refund amount is the portion of the original finance charge that is applicable to all fully unexpired months in the contract as originally scheduled or, if deferred, as deferred, following the date of prepayment.

History: **En. Sec. 9, Ch. 282, L. 1959; R.C.M. 1947, 74-609; amd. Sec. 1, Ch. 135, L. 1983; amd. Sec. 11, Ch. 63, L. 2013.**

Cross-References

Consumer loan businesses — charges, refunds, penalties, and filing fees, 32-5-301.

31-1-243. Refinancing retail installment contract. The holder of a contract, upon request by the buyer, may extend the scheduled due date of all or any part of any installment or installments or defer payment or payments or renew or restate the unpaid time balance of the contract, the amount of the installments, and the time schedule for the installments and may collect for the extension, deferment, renewal, or restatement a refinance charge. The holder may compute the refinance charge on the unpaid time balance to be extended, deferred, renewed, or restated by adding to the unpaid time balance the cost for any insurance and other benefits incidental to the refinancing plus any accrued delinquency and collection charges, after deducting any refund that may be due the buyer as for a prepayment pursuant to 31-1-242 at the rate of the finance charge specified in 31-1-241. If all unpaid installments are deferred for not more than 2 months, the holder may charge and collect for the deferment an amount equal to the difference between the refund required for prepayment in full under 31-1-242 as of the scheduled due date of the first deferred installment and the refund required for prepayment in full as of 1 month prior to the date, times the number of months in which a scheduled payment is not made.

History: **En. Sec. 10, Ch. 282, L. 1959; amd. Sec. 2, Ch. 284, L. 1977; R.C.M. 1947, 74-610; amd. Sec. 2, Ch. 88, L. 1979; amd. Sec. 3, Ch. 276, L. 1981; amd. Sec. 1, Ch. 22, L. 1983; amd. Sec. 976, Ch. 56, L. 2009.**

Cross-References

When interest becomes part of principal, 31-1-109.
Consumer loan businesses — deferral charge permitted — nature of deferral charge, 32-5-321.
Consumer loan businesses — deferral charge — rate, 32-5-322.

Part 3
Wage Brokers

31-1-301. Wage brokers to procure license and give bond. No person, company, corporation, or association may establish or conduct the business of wage broker within the state unless such person, company, corporation, or association procures a license from the proper authorities and executes a bond in such sum as the authorities may require for the faithful carrying out of the provisions of this part and of the ordinances of any town or city in which the business may be carried on.

History: **En. Sec. 1, Ch. 56, L. 1911; re-en. Sec. 4173, R.C.M. 1921; re-en. Sec. 4173, R.C.M. 1935; R.C.M. 1947, 41-1501; amd. Sec. 3, Ch. 88, L. 1979.**

31-1-302. Issuance of license — terms and amount thereof. The board of county commissioners of any county in this state or, in case said business be carried on in any incorporated city or town, the city council or board of trustees of said city or town may in its discretion, from time to time, grant licenses to any person or persons, company, corporation, or association to conduct or carry on the business of wage broker upon payment of such sum therefor and upon such terms and conditions as the said board of county commissioners or city council or board of trustees shall by resolution or ordinance require.

History: En. Sec. 2, Ch. 56, L. 1911; re-en. Sec. 4174, R.C.M. 1921; re-en. Sec. 4174, R.C.M. 1935; R.C.M. 1947, 41-1502.

Cross-References

General county licensing authority, Title 7, ch. 21, part 21.
General licensing authority of municipalities, 7-21-4101.
Licensing — discrimination prohibited, 49-3-204.

31-1-303. Wage broker defined. Any person, company, corporation, or association parting with, giving, or loaning money, either directly or indirectly, to any employee or wage earner, upon the security of or in consideration of any assignment or transfer of wages or salary of such employee or wage earner, shall be deemed to be a wage broker within the meaning of this part.

History: En. Sec. 3, Ch. 56, L. 1911; re-en. Sec. 4175, R.C.M. 1921; re-en. Sec. 4175, R.C.M. 1935; R.C.M. 1947, 41-1503.

31-1-304. Restrictions upon assignment of wages or salary. An assignment of wages or salary by any employee or wage earner to any wage broker for the employee's or wage earner's benefit is not valid or enforceable, and an employer or debtor may not recognize or honor the assignment for any purpose whatever unless the assignment is for a fixed and definite part or all of the wages or salary earned.

History: En. Sec. 4, Ch. 56, L. 1911; re-en. Sec. 4176, R.C.M. 1921; re-en. Sec. 4176, R.C.M. 1935; R.C.M. 1947, 41-1504; amd. Sec. 977, Ch. 56, L. 2009.

Cross-References

Consumer loan businesses — wage assignments — limitations, 32-5-310.

31-1-305. Interest on loans — amount and computation. A wage broker may not ask, demand, or receive, either as compensation or interest or in any other manner, directly or indirectly, any compensation or interest for the use of money advanced or loaned by the wage broker to any employee or wage earner in excess of 12% a year. The compensation or rate of interest must be computed upon the amount actually advanced to and received by the employee or wage earner and must include all commissions or compensation whatsoever to the wage broker or any other person for making or procuring the loan.

History: En. Sec. 5, Ch. 56, L. 1911; re-en. Sec. 4177, R.C.M. 1921; re-en. Sec. 4177, R.C.M. 1935; R.C.M. 1947, 41-1505; amd. Sec. 978, Ch. 56, L. 2009.

Cross-References

Legal interest, 31-1-106.
Interest rate allowed by agreement, 31-1-107.
Consumer loan businesses — charges, refunds, penalties, and filing fees, 32-5-301.

31-1-306. Spouse must join in assignment of wages — acknowledgment. No assignment of wages or salary to a wage broker by a married person who shall have a spouse residing in this state shall be valid or enforceable without the consent of such spouse, evidenced by the spouse's signature to said assignment, executed and acknowledged before a notary public or other officer empowered to take acknowledgments. No wage broker or person connected with a wage broker, directly or indirectly, shall be authorized to take any such acknowledgments.

History: En. Sec. 6, Ch. 56, L. 1911; re-en. Sec. 4178, R.C.M. 1921; re-en. Sec. 4178, R.C.M. 1935; amd. Sec. 23, Ch. 535, L. 1975; R.C.M. 1947, 41-1506.

Cross-References

Consumer loan businesses — wage assignments — limitations, 32-5-310.
Earnings and accumulations of married person, 40-2-205.
Work and labor of married person, 40-2-207.

31-1-307. Assignments invalid without notice to employer — filing assignments. No assignment of wages or salary to a wage broker shall be valid or enforceable unless notice in writing of the same, accompanied by a copy of the assignment, shall be given to the employer within 1 day from the date of its execution. All assignments shall be filed in the office of the county clerk of the county where the assignor resides, and no assignment shall be valid unless so filed.

History: **En. Sec. 7, Ch. 56, L. 1911; re-en. Sec. 4179, R.C.M. 1921; re-en. Sec. 4179, R.C.M. 1935; R.C.M. 1947, 41-1507.**

Cross-References

Role and duties of County Clerk and Election Administrator, 7-4-2611.
What contracts must be in writing, 28-2-903.
Discharge or layoff of employee because of attachment or garnishment prohibited, 39-2-302.

31-1-308. Assignment to be considered a loan. Every purchase by a wage broker of an assignment of the wages or salary of any employee or wage earner shall be held and considered a loan, in the sum of the amount actually paid to and received by such employee or wage earner, and shall be subject to all the provisions of this part.

History: **En. Sec. 8, Ch. 56, L. 1911; re-en. Sec. 4180, R.C.M. 1921; re-en. Sec. 4180, R.C.M. 1935; R.C.M. 1947, 41-1508.**

Cross-References

Loan of money — what constitutes, 31-1-101.
Engaging in business of making loans restricted, 32-5-103.
Consumer loan businesses — wage assignments — limitations, 32-5-310.

31-1-309. Violation — penalties. Any person, company, corporation, or association and any officer, member, agent, or employee thereof violating any or either of the provisions of 31-1-301 to 31-1-308, both inclusive, shall be deemed guilty of a misdemeanor and upon conviction shall be liable to a fine in the sum of not less than $100 or more than $500 for each offense or to imprisonment in the county jail for a period not to exceed 90 days, or both, and in addition thereto the debt and accrued interest thereon shall be discharged and the security shall be void.

History: **En. Sec. 9, Ch. 56, L. 1911; re-en. Sec. 4181, R.C.M. 1921; amd. Sec. 1, Ch. 112, L. 1929; re-en. Sec. 4181, R.C.M. 1935; R.C.M. 1947, 41-1509.**

Cross-References

Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.

31-1-310. When note, instrument, or assignment void. Any note, bill, or other evidence of indebtedness and any assignment of wages or salary given to or received by any wage broker in violation of any of the provisions of this part shall be void as against the creditors of the assignor or transferor.

History: **En. Sec. 10, Ch. 56, L. 1911; re-en. Sec. 4182, R.C.M. 1921; re-en. Sec. 4182, R.C.M. 1935; R.C.M. 1947, 41-1510.**

Cross-References

When contract wholly void, 28-2-603.
Contracts — illegal objects and provisions, Title 28, ch. 2, part 7.

Part 4
Pawnbrokers

Part Cross-References

Regulation of pawnbrokers located outside incorporated city or town — definition, 7-21-2120.
Regulation of pawnbrokers by city government, 7-21-4201, 7-21-4207, 7-21-4208.
Theft by disposal of stolen property, 45-6-314.
Pawnbroker to surrender stolen property — warrant, 46-5-212.

31-1-401. Interest pawnbrokers may receive — civil enforcement — prohibited activities. (1) A person may not carry on the business of pawnbroker or junk dealer by receiving goods pawned or in pledge for loans at any rate of interest above 10% a year without first obtaining a license. A pawnbroker or junk dealer or the pawnbroker's or junk dealer's employees or agents may not charge a fee of more than 25% of the amount of the loan for a 30-day period. The fee for extending a pawn agreement for 30 days may not exceed 25% of the amount of the loan. For purposes of this section, a fee includes all costs or fees charged, including but not limited to interest, commission, discount, storage, care of property, and purchase option.

(2) The taking, receiving, reserving, or charging of a fee greater than that allowed under subsection (1) is considered a forfeiture of a sum double the amount of the fee for storage or caring that was agreed to be paid.

(3) (a) When a rate or charge greater than that provided for in subsection (1) has been paid, the person by whom it has been paid may recover from the pawnbroker or junk dealer reasonable attorney fees and an amount double the amount of the fee paid.

(b) An action under this subsection (3) must be brought within 2 years after the payment of the fee. Before a suit may be brought, the party bringing suit shall make written demand for return of the fee paid.

(4) Unless licensed as a consumer loan licensee or a deferred deposit loan licensee, a pawnbroker or junk dealer may not:

(a) cash or advance money for a postdated or deferred presentment check in exchange for a fee or finance charge;

(b) use a check, authorization for electronic access, or other method of access to a deposit account, savings account, or other financial or asset account as a condition of or security for an extension of credit;

(c) receive the title to a motor vehicle for the purpose of a pawn transaction or in pledge for a loan; or

(d) engage in any device or subterfuge intended to evade the requirements of this chapter, including assisting a borrower to obtain a loan at a rate of interest prohibited by Montana law, making loans disguised as personal property sales and leaseback transactions, or disguising loan proceeds as cash rebates for the pretextual installment sale of goods or services.

(5) In addition to other penalties provided by law, a violation of subsection (4) is a violation of Title 30, chapter 14, part 1.

History: En. Secs. 1 to 8, pp. 206-207, L. 1889; amd. Sec. 3310, Pol. C. 1895; Sec. 2105, Rev. C. 1907; re-en. Sec. 4186, R.C.M. 1921; re-en. Sec. 4186, R.C.M. 1935; amd. Sec. 12, Ch. 185, L. 1977; R.C.M. 1947, 66-1601; amd. Sec. 1, Ch. 258, L. 1993; amd. Sec. 5, I.M. No. 164, approved Nov. 2, 2010; amd. Sec. 4, Ch. 278, L. 2013.

Cross-References

Regulation of pawnbrokers, 7-21-2120.
Cities may license, 7-21-4201.
Legal interest, 31-1-106.
Engaging in business of making loans restricted, 32-5-103.
Consumer loan businesses — charges, refunds, penalties, and filing fees, 32-5-301.

31-1-402. Pawnbroker to keep register. (1) Every pawnbroker or junk dealer shall keep a register, in which must be entered a description of every article pawned to or purchased by the pawnbroker or junk dealer, with:

(a) the date of the pawning or purchasing;

(b) the date when the article must be redeemed;

(c) the name of the person who pawned or sold the article; and

(d) the amount loaned on or paid for the article.

(2) The register must be made available for inspection and examination by any peace officer.

History: En. Secs. 1 to 8, pp. 206-207, L. 1889; amd. Sec. 3315, Pol. C. 1895; re-en. Sec. 2110, Rev. C. 1907; re-en. Sec. 4191, R.C.M. 1921; re-en. Sec. 4191, R.C.M. 1935; R.C.M. 1947, 66-1606; amd. Sec. 979, Ch. 56, L. 2009; amd. Sec. 1, Ch. 222, L. 2015.

Cross-References

Authority to require records for pawn, secondhand, and junk shops, 7-21-4207.
Unlawful transactions with children, 45-5-623.

31-1-403. Repealed. Sec. 2, Ch. 344, L. 1993.

History: En. Secs. 1 to 8, pp. 206-207, L. 1889; amd. Sec. 3311, Pol. C. 1895; re-en. Sec. 2106, Rev. C. 1907; re-en. Sec. 4187, R.C.M. 1921; re-en. Sec. 4187, R.C.M. 1935; amd. Sec. 54, Ch. 359, L. 1977; R.C.M. 1947, 66-1602.

31-1-404. Repealed. Sec. 2, Ch. 344, L. 1993.

History: En. Secs. 1 to 8, pp. 206-207, L. 1889; amd. Sec. 3312, Pol. C. 1895; re-en. Sec. 2107, Rev. C. 1907; re-en. Sec. 4188, R.C.M. 1921; re-en. Sec. 4188, R.C.M. 1935; R.C.M. 1947, 66-1603.

31-1-405. Repealed. Sec. 2, Ch. 344, L. 1993.

History: En. Secs. 1 to 8, pp. 206-207, L. 1889; amd. Sec. 3313, Pol. C. 1895; re-en. Sec. 2108, Rev. C. 1907; re-en. Sec. 4189, R.C.M. 1921; re-en. Sec. 4189, R.C.M. 1935; R.C.M. 1947, 66-1604.

31-1-406. Repealed. Sec. 2, Ch. 344, L. 1993.

History: En. Secs. 1 to 8, pp. 206-207, L. 1889; amd. Sec. 3314, Pol. C. 1895; re-en. Sec. 2109, Rev. C. 1907; re-en. Sec. 4190, R.C.M. 1921; re-en. Sec. 4190, R.C.M. 1935; R.C.M. 1947, 66-1605.

31-1-407. Violation a misdemeanor. A violation of any of the provisions of this part is a misdemeanor.

History: **En. Secs. 1 to 8, pp. 206-207, L. 1889; amd. Sec. 3316, Pol. C. 1895; re-en. Sec. 2111, Rev. C. 1907; re-en. Sec. 4192, R.C.M. 1921; re-en. Sec. 4192, R.C.M. 1935; amd. Sec. 21, Ch. 513, L. 1973; amd. Sec. 13, Ch. 185, L. 1977; R.C.M. 1947, 66-1607.**

Cross-References

Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.
Penalty when none specified, 46-18-212.

Part 5
Retail Sales — Late Payment Charges

Part Cross-References

U.C.C. — sales, Title 30, ch. 2.

31-1-501. Late payment charges — accounts receivable for merchandise sold at retail. (1) Notwithstanding 31-1-106 or 31-1-107, a person who sells goods, as defined in 31-1-202, at retail to a retail buyer who promises to pay for such goods upon presentation of the bill therefor, may charge and collect a late payment charge not greater than 1½% per month on all money due on all accounts from 30 days after the date on which the obligation of the buyer to pay is incurred.

(2) The late payment charge provided in this section may be charged only if at the time the obligation was incurred the seller did not intend to extend any credit beyond 30 days and any late payment of the obligation was unintended.

(3) The provisions of this section do not apply to money due for intangible services, for services regulated by the public service commission, for real property, for health care services, or for retail installment sales contracts or retail charge account agreements regulated under Title 31, chapter 1, part 2.

History: **En. Sec. 1, Ch. 222, L. 1981.**

31-1-502. Periodic statement to be furnished to debtor. (1) A seller may charge the late payment charge provided for in 31-1-501 only if the seller promptly supplies the buyer with a statement as of the end of each monthly period or other regular period agreed upon by the seller and the buyer in which there is any unpaid balance. The statement must recite the following:

(a) the percentage amount of the late payment charge that will be charged beginning 30 days after the obligation is incurred;

(b) the unpaid balance at the beginning or end of the period;

(c) an identification of any amounts debited to the buyer's account during the period;

(d) the payments made by the buyer to the seller during the period;

(e) the amount of the late payment charge and also the percentage annual simple interest equivalent of the amount; and

(f) a legend to the effect that the buyer may at any time pay the total unpaid balance.

(2) The items need not be stated in the sequence or order set forth in subsection (1). Additional items may be included to explain the computations made in determining the amount to be paid by the buyer.

History: **En. Sec. 2, Ch. 222, L. 1981; amd. Sec. 980, Ch. 56, L. 2009.**

Part 6
State-Sponsored Credit Card
(Repealed)

31-1-601. Repealed. Sec. 2, Ch. 252, L. 1995.

History: **En. Sec. 1(4), Ch. 637, L. 1989.**

31-1-602. Repealed. Sec. 2, Ch. 252, L. 1995.

History: **En. Sec. 1(1), (2), Ch. 637, L. 1989; amd. Sec. 9, Ch. 593, L. 1993.**

31-1-603. Repealed. Sec. 2, Ch. 252, L. 1995.

History: **En. Sec. 1(3), Ch. 637, L. 1989.**

Part 7
Montana Deferred Deposit Loan Act

31-1-701. Short title. This part may be cited as the "Montana Deferred Deposit Loan Act".
History: En. Sec. 1, Ch. 404, L. 1999.

31-1-702. Purpose — rules — fees. (1) The purpose of this part is to protect consumers who enter into short-term, high-rate loans with lenders from abuses that occur in the credit marketplace when the lenders are unregulated.

(2) The department may adopt rules to implement the provisions of this part. The rules may include but are not limited to rules establishing forms and procedures for licensing, rules pertaining to acceptable practices at a business location, rules establishing disclosure requirements, and rules establishing complaint and hearing procedures.

(3) All fees collected pursuant to the provisions of this part must be deposited in the department's special revenue account to be used by the department in carrying out its supervisory functions under this part.
History: En. Sec. 2, Ch. 404, L. 1999; amd. Sec. 2, Ch. 451, L. 2007.

31-1-703. Definitions. For the purposes of this part, the following definitions apply:

(1) "Account" means any banking, checking, credit union, commercial, savings, savings and loan, brokerage, investment, or other kind of depository account held by a consumer.

(2) "Check" means a negotiable instrument, as defined in 30-3-104, that is drawn on a state or federal bank, credit union, or savings and loan association and is payable on demand at the maturity of a deferred deposit loan.

(3) "Consumer" means a natural person who, singly or jointly with another natural person, enters into a deferred deposit loan.

(4) "Deferred deposit lender" or "licensee" means a person engaged in the business of making deferred deposit loans.

(5) "Deferred deposit loan" means an arrangement, including all representations made by the deferred deposit lender whether express or implied, in which:

(a) a person accepts a check dated on the date on which the check is written and agrees to hold the check for a period of days prior to deposit or presentment;

(b) a person accepts a check dated subsequent to the date on which the check is written and agrees to hold the check for deposit or presentment until the date written on the check; or

(c) a person accepts written authorization from a consumer to electronically deduct from the consumer's account on a specific date the amount of the loan and fees that are authorized under this part.

(6) "Department" means the department of administration.

(7) "Person" means a natural person, sole proprietorship, firm, partnership, corporation, or other entity.
History: En. Sec. 3, Ch. 404, L. 1999; amd. Sec. 1, Ch. 81, L. 2001; amd. Sec. 71, Ch. 483, L. 2001; amd. Sec. 3, Ch. 451, L. 2007.

31-1-704. Scope. (1) This part applies to deferred deposit lenders and to persons who facilitate, enable, or act as a conduit for persons making deferred deposit loans.

(2) This part does not apply to retail sellers who cash checks incidental to or independent of a sale and who do not charge more than $2 a check for the service.
History: En. Sec. 4, Ch. 404, L. 1999; amd. Sec. 2, Ch. 81, L. 2001; amd. Sec. 70, Ch. 114, L. 2003; amd. Sec. 1, Ch. 221, L. 2003; amd. Sec. 8, Ch. 163, L. 2005; amd. Sec. 3, Ch. 81, L. 2009.

31-1-705. License — application requirements — business locations. (1) A person may not engage in or offer to engage in the business of making deferred deposit loans unless licensed by the department. A license may be granted to a person located within the state or to a person located outside of the state who uses the internet, facsimiles, or third persons to conduct transactions with consumers in this state.

(2) An applicant for a license to engage in the business of making deferred deposit loans shall pay to the department a license application fee of $500. The department may direct that applicants remit fees to the department through a nationwide licensing system.

(3) The application for licensure must be in the form and submitted in the manner that the department directs.

(4) The license year is the calendar year, and all licenses expire on December 31 of each year.

(5) Each licensee shall post a bond in the amount of $10,000 for each location at or from which deferred deposit loan transactions are conducted with consumers in this state. The bond must continue in effect for 2 years after the licensee ceases operation in the state. The bond must be available to pay damages authorized under this part to consumers harmed by any violation of this part and to pay civil penalties, restitution, and costs ordered by the department pursuant to 31-1-712 for any violation of this part.

(6) More than one place of business may not be maintained under the same license. A person shall obtain a license for the person's principal place of business and a separate branch license for each additional place of business or location at or from which deferred deposit loan transactions are conducted with consumers in this state.

History: **En. Sec. 5, Ch. 404, L. 1999; amd. Sec. 3, Ch. 81, L. 2001; amd. Sec. 1, Ch. 119, L. 2005; amd. Sec. 4, Ch. 451, L. 2007; amd. Sec. 4, Ch. 81, L. 2009; amd. Sec. 2, Ch. 96, L. 2013; amd. Sec. 1, Ch. 277, L. 2013.**

31-1-706. License renewal fee. (1) A person licensed under 31-1-705 shall pay an annual license renewal fee of $500 for each license that the person holds under this part.

(2) The department may direct that fees due the department under subsection (1) be remitted to the department through a nationwide licensing system.

History: **En. Sec. 4, Ch. 81, L. 2001; amd. Sec. 5, Ch. 451, L. 2007; amd. Sec. 2, Ch. 277, L. 2013.**

31-1-707. Denial of license and license renewal. (1) (a) Except as provided in subsection (1)(b), the department shall deny any new license or refuse to renew any license if:

(i) the applicant does not meet the qualifications stated in this part or in rules adopted pursuant to this part;

(ii) the department finds that the criminal history of any employee of the applicant at the time of application or renewal demonstrates any conviction involving fraud or financial dishonesty or if the department's findings show civil judgments involving fraudulent or dishonest financial dealings;

(iii) the financial responsibility, experience, character, and general fitness of the applicant do not warrant the belief that the business will be operated lawfully and fairly and within the provisions of this part;

(iv) the applicant does not have unencumbered assets of at least $25,000 for each location to be operated by the applicant;

(v) other information that the department considers necessary has not been provided; or

(vi) the applicant makes any material misstatement of fact or any material omission of fact in the application.

(b) A denial is not required pursuant to subsection (1)(a)(ii) if the department finds that the applicant dismissed the employee promptly upon learning of the employee's conviction involving fraud or financial dishonesty or of civil judgments involving fraudulent or dishonest financial dealings by the employee.

(2) The department shall provide written notice to the applicant of the denial or refusal, setting forth in the notice the grounds upon which the denial or refusal is based.

(3) The applicant has the right to a hearing under the Montana Administrative Procedure Act on any denial or refusal to issue a license. The request for a hearing must be made within 14 days of the date of receipt of the written notice of denial or refusal.

(4) An applicant whose application for licensure or renewal has been denied or refused may not reapply for 1 year following the denial or refusal.

History: **En. Sec. 1, Ch. 81, L. 2009; amd. Sec. 3, Ch. 96, L. 2013; amd. Sec. 3, Ch. 277, L. 2013.**

31-1-708 and 31-1-709 reserved.

31-1-710. Department authorized to participate in nationwide licensing system for purposes of licensing deferred deposit loan licensees — rulemaking. (1) The department may participate in a nationwide licensing system for licensing purposes under this part and may require deferred deposit loan license applicants to apply for licensure in the manner that the department may direct on applications approved by the nationwide licensing system.

(2) The department may establish rules that are necessary to comply with the nationwide licensing system protocols and procedures pertaining to fees, renewal dates, amending or surrendering a license, and any other activity necessary for participation in the nationwide licensing system.

(3) The department's portion of the licensing fees collected through the nationwide licensing system must be deposited into the department's account in the state special revenue fund for use in the administration of this part.

History: **En. Sec. 7, Ch. 277, L. 2013.**

Cross-References

Department authorized to participate in nationwide licensing system for purposes of licensing sales finance companies — rulemaking, 31-1-223.

Department authorized to participate in nationwide licensing system for purposes of licensing consumer loan licensees — rulemaking, 32-5-209.

Department authority to utilize nationwide licensing system for licensing escrow businesses, 32-7-112.

31-1-711. Examinations — fee. (1) The department may conduct an examination of each licensee's deferred deposit lending operation to ensure that the licensee is in compliance with the provisions of this part.

(2) (a) A licensee shall pay the department a fee in the amount of $37.50 an hour for each examiner required to conduct an examination.

(b) The department may charge a licensee for no more than three examinations a year under this section.

(3) A licensee shall make available to a department examiner the information required under 31-1-714 or as required by rule.

History: **En. Sec. 6, Ch. 404, L. 1999; amd. Sec. 6, Ch. 451, L. 2007; amd. Sec. 5, Ch. 81, L. 2009.**

31-1-712. Notice of violation — administrative hearing — penalties — liability. (1) If the department has probable cause to believe that a licensed or unlicensed person has violated any of the provisions of this part, a rule promulgated under this part, or an order issued by the department or has made a material misrepresentation to the department by act or omission, the department may issue a notice stating the alleged violation to the person.

(2) (a) The notice referred to in subsection (1) must comply with 2-4-601 and must include a statement that the person has an opportunity to request an administrative hearing under the Montana Administrative Procedure Act within 14 days of the date that the department's notice was mailed to the person.

(b) The department shall mail the notice by certified mail to a licensee's address of record with the department or to an unlicensed person at an address for the person known to the department. The department has complied with the service of process upon mailing the notice by certified mail.

(3) If a person served with a notice under subsection (2) admits to or does not contest having violated or is found after an administrative hearing to have violated this part, a rule promulgated under this part, or an order issued by the department or to have made a material misrepresentation to the department by act or omission, the department may impose a civil penalty not to exceed $1,000 for each violation and may issue an order revoking or suspending the right of the person or licensee, directly or through an officer, agent, employee, or representative, to do business in this state as a licensee or to engage in the business of making deferred deposit loans. In addition, the department may order restitution to borrowers and reimbursement for the department's cost in bringing the administrative action. The department's remedies specified in this part are cumulative, except that the remedies in 31-1-724 pertaining to a consumer's private rights of action are not available to the department.

(4) In addition to the penalties in subsection (3), any deferred deposit loan made by an unlicensed person is void, and the unlicensed person may not directly or indirectly collect, receive, or retain any loan principal, interest, fees, or other charges related to the loan.

(5) A revocation, suspension, or surrender of a license does not relieve the licensee from civil or criminal liability for acts committed prior to the revocation, suspension, or surrender of the license.

(6) The department may reinstate any suspended or revoked license if there is not a fact or condition existing at the time of reinstatement that would have justified the department's

refusal to originally issue the license. If a license has been suspended or revoked for cause, an application may not be made for the issuance of a new license or the reinstatement of a suspended or revoked license for a period of 6 months from the date of suspension or revocation.

(7) All civil penalties collected pursuant to this section must be deposited in the state general fund.

History: En. Sec. 7, Ch. 404, L. 1999; amd. Sec. 2, Ch. 221, L. 2003; amd. Sec. 7, Ch. 451, L. 2007; amd. Sec. 4, Ch. 277, L. 2013; amd. Sec. 1, Ch. 23, L. 2015.

31-1-713. Department obligations — complaints. (1) The department shall maintain, either directly or indirectly through a nationwide licensing system, a list of licensees that is available to and accessible by interested persons and the general public.

(2) The department shall also establish by rule a procedure under which an aggrieved consumer or any member of the public may file a complaint against a licensee or an unlicensed person.

(3) If the department determines there is probable cause to issue and serve a notice under 31-1-712 to a licensed or unlicensed person against whom a complaint has been filed by a consumer or other member of the public, the department is obligated to provide only the licensee or the unlicensed person with the opportunity to request an administrative hearing.

History: En. Sec. 8, Ch. 404, L. 1999; amd. Sec. 8, Ch. 451, L. 2007; amd. Sec. 5, Ch. 277, L. 2013; amd. Sec. 2, Ch. 23, L. 2015.

31-1-714. Information and annual reports. (1) Each licensee shall keep and use books, accounts, and records that will enable the department to determine if the licensee is complying with the provisions of this part and maintain any other records required by the department. The department is authorized to examine the records at any reasonable time. The records must be kept for 2 years following the last entry on a loan and must be kept according to generally accepted accounting procedures that include an examiner being able to review the recordkeeping and reconcile each deferred deposit loan with documentation maintained in the consumer's loan file records.

(2) Each licensee shall submit an annual report with the department on the date and in the form and manner that the department directs regarding the licensee's deferred deposit loan activity with consumers in this state during the preceding calendar year. The report must contain the following information:

(a) the resources, assets, and liabilities of the licensee at the beginning and the end of the period;

(b) the income, expense, gain, loss, and balance sheets;

(c) the total number of deferred deposit loans made in the year ending as of December 31 of the previous year, including:

(i) the number of individual consumers with 12 or fewer new deferred deposit loans; and

(ii) the number of individual consumers with 13 or more new deferred deposit loans;

(d) the average deferred deposit loan amount, average annual interest percentage rate, and average deferred deposit loan term;

(e) the number of deferred deposit loans rescinded;

(f) the total number of deferred deposit loans outstanding as of December 31 of the previous year;

(g) the minimum and maximum amount of checks for which deposits were deferred in the year ending as of December 31 of the previous year;

(h) the total number and dollar amount of returned checks, the total number and dollar amount of checks recovered, and the total number and dollar amount of checks charged off during the year ending as of December 31 of the previous year;

(i) the total number and dollar amount of agreements involving electronic transactions or deductions, the total number and dollar amount of electronic deductions made by the licensee, and the total number and dollar amount of electronic deductions for insufficient funds charged off during the year ending as of December 31 of the previous year; and

(j) verification that the licensee has not used a criminal process or caused a criminal process to be used in the collection of any deferred deposit loans or used any civil process to collect the payment of deferred deposit loans not generally available to creditors to collect on loans in default during the year ending as of December 31 of the previous year.

(3) A report must be executed by an individual representative of the licensee in the manner the department may direct, and the department may require that the report be executed in conformance with any protocols of a nationwide licensing system.

(4) (a) If a licensee conducts another business or is affiliated with other licensees under this part or if any other situation exists under which allocations of expense are necessary, the licensee shall make the allocation according to appropriate and reasonable accounting principles as approved by the department.

(b) Information about any other business conducted on the same premises where deferred deposit loans are made must be provided as required by the department.

(5) Each licensee shall file a copy of the disclosure documents described in 31-1-721 with the department prior to the date of commencement of business at each location, at the time any changes are made to the documents, and annually upon renewal of the license. These documents must be available to interested parties and to the general public through the department.

History: En. Sec. 9, Ch. 404, L. 1999; amd. Sec. 5, Ch. 81, L. 2001; amd. Sec. 2, Ch. 119, L. 2005; amd. Sec. 9, Ch. 451, L. 2007; amd. Sec. 4, Ch. 96, L. 2013; amd. Sec. 6, Ch. 277, L. 2013.

31-1-715. Loan requirements — right of rescission — arbitration — completion of transaction. (1) A deferred deposit loan may not have a term that exceeds 31 days.

(2) The amount of the deferred deposit loan, exclusive of the fee allowed in 31-1-722(2), may not exceed $300.

(3) The minimum amount of a deferred deposit loan is $50.

(4) The check written by the consumer in a deferred deposit loan must be made payable to the licensee.

(5) (a) The loan agreement must contain a provision that the consumer may rescind the transaction if, by 5 p.m. of the licensee's first business day following the day that the loan was executed, the consumer provides the licensee with cash or certified funds equaling 100% of the amount loaned to the consumer.

(b) A licensee may not charge a consumer any fee or interest if the consumer rescinds the loan as provided in subsection (5)(a).

(c) Except as provided in subsection (5)(a), a consumer does not have a right to rescind the loan unless the licensee agrees to the rescission.

(6) (a) A loan agreement may not contain a mandatory arbitration clause that is oppressive, unconscionable, unfair, or in substantial derogation of a consumer's rights.

(b) A mandatory arbitration clause that complies with the applicable standards of the American arbitration association must be presumed to not violate the provisions of subsection (6)(a).

(7) Only the licensee may make an electronic deduction from the consumer's account. The licensee shall ensure that information obtained from the consumer about the consumer's account remains confidential.

(8) The licensee shall provide the consumer, or each consumer if there is more than one, with a copy of the loan documents described in 31-1-721 upon consummation of the loan.

(9) The holder or assignee of any check written by a consumer in connection with a deferred deposit loan takes the instrument subject to all claims and defenses of the consumer.

(10) A deferred deposit loan transaction is completed when the licensee receives payment in full from the consumer in cash or, if payment is made by check or electronic transfer from the consumer's account, when the check or electronic transfer is debited to the consumer's account by the consumer's financial institution. Once a deferred deposit loan transaction is complete, a licensee may enter into a new deferred deposit loan with the consumer. Deferred deposit loans may not be renewed or extended.

History: En. Sec. 10, Ch. 404, L. 1999; amd. Sec. 6, Ch. 81, L. 2001; amd. Sec. 1, Ch. 210, L. 2005; amd. Sec. 10, Ch. 451, L. 2007.

31-1-716 through 31-1-720 reserved.

31-1-721. Required disclosures — loan agreement. (1) Before entering into a deferred deposit loan, the licensee shall deliver to the consumer a pamphlet prepared by or at the direction of the department that:

(a) explains, in simple language, all of the consumer's rights and responsibilities in a deferred deposit loan transaction;

(b) includes a telephone number to the department's office that handles concerns or complaints by consumers; and

(c) informs consumers that the department's office can provide information about whether a lender is licensed and other legally available information.

(2) Licensees shall provide consumers with a written agreement on a form specified or approved by the department that can be kept by the consumer, which must include the following information:

(a) the name, address, and phone number of the licensee making the deferred deposit loan and the initials or other written means of identifying the individual employee who signs the agreement on behalf of the licensee;

(b) the name, address, and phone number of the consumer obtaining the deferred deposit loan;

(c) all disclosures required by the federal Truth in Lending Act, 15 U.S.C. 1601, et seq.;

(d) a clear description of the consumer's payment obligations under the loan; and

(e) in a manner that is more conspicuous than the other information provided in the loan document and that is in at least 14-point bold typeface, a statement that "you cannot be prosecuted in criminal court for collection of this loan". The statement must be located immediately preceding the signature of the consumer.

History: **En. Sec. 11, Ch. 404, L. 1999; amd. Sec. 3, Ch. 221, L. 2003; amd. Sec. 11, Ch. 451, L. 2007.**

31-1-722. Prohibited and permitted fees — attorney fees and costs. (1) A licensee may not charge or receive, directly or indirectly, any interest, fees, or charges except those specifically authorized by this section.

(2) A licensee may not charge a fee for making or carrying each deferred deposit loan authorized by this part that exceeds 36% per annum, exclusive of the insufficient funds fees authorized in subsections (3) and (4).

(3) If there are insufficient funds to pay a check on the date of presentment, a licensee may charge a fee, not to exceed $30. Only one fee may be collected pursuant to this subsection with respect to a particular check even if it has been redeposited and returned more than once. A fee charged pursuant to this subsection is a licensee's exclusive charge for late payment. A licensee or any collection agency acting as an agent of a licensee, as a holder in due course of a licensee, or under an agreement with a licensee to collect amounts due or asserted to be due may not collect damages under 27-1-717(3) for an insufficient funds check.

(4) If the loan involves an electronic deduction and there are insufficient funds to deduct on the date on which the payment is due, a licensee may charge a fee, not to exceed $30. Only one fee may be collected pursuant to this subsection with respect to a particular loan even if the licensee has attempted more than once to deduct the amount due from the consumer's account. A fee charged pursuant to this subsection is a licensee's exclusive charge for late payment. A licensee or any collection agency acting as an agent of a licensee, as a holder in due course of a licensee, or under an agreement with a licensee to collect amounts due or asserted to be due may not collect damages under 27-1-717(3) for an electronic deduction for which there are insufficient funds.

(5) If the loan agreement in 31-1-721 requires, reasonable attorney fees and court costs may be awarded to the party in whose favor a final judgment is rendered in any action on a deferred deposit loan entered into pursuant to this part.

History: **En. Sec. 12, Ch. 404, L. 1999; amd. Sec. 7, Ch. 81, L. 2001; amd. Sec. 4, Ch. 221, L. 2003; amd. Sec. 6, Ch. 81, L. 2009; amd. Sec. 6, I.M. No. 164, approved Nov. 2, 2010.**

31-1-723. Prohibited acts. A licensee making deferred deposit loans may not commit, or have committed on behalf of the licensee, any of the following prohibited acts:

(1) engaging in the business of deferred deposit lending unless the department has first issued a valid license;

(2) threatening to use or using a criminal process in this or any other state to collect on the loan made to a consumer in this state or any civil process to collect the payment of deferred deposit loans not generally available to creditors to collect on loans in default;

(3) altering the date or any other information on a check received from a consumer;

(4) altering or changing the date upon which the licensee and consumer agreed to make any electronic deductions from the consumer's account unless the consumer agrees in writing to the change;

(5) making any false, misleading, or deceptive representation to a financial institution relating to a consumer who has agreed to provide payment for a loan through an electronic deduction;

(6) using any device or agreement that would have the effect of charging or collecting more fees, charges, or interest than those allowed by this part, including but not limited to entering into a different type of transaction or renewing or rolling over a loan with the consumer;

(7) engaging in unfair, deceptive, or fraudulent practices in the making or collection of a deferred deposit loan;

(8) entering into a deferred deposit loan with a consumer that is unconscionable. In determining whether a deferred deposit loan transaction is unconscionable, consideration must be given to, but is not limited to, whether the amount of the loan exceeds 25% of the consumer's monthly net income.

(9) charging to cash a check representing the proceeds of the deferred deposit loan;

(10) charging to perform an electronic deduction or transaction to obtain the proceeds of the deferred deposit loan;

(11) using or attempting to use the check provided by the consumer in a deferred deposit loan as security for purposes of any state or federal law;

(12) using or attempting to use the consumer's authorization to deduct the amount set forth in the loan agreement or any other information obtained from the consumer or the consumer's financial institution for any purpose other than to collect the proceeds of the deferred deposit loan;

(13) accepting payment of the deferred deposit loan through the proceeds of another deferred deposit loan;

(14) entering into a deferred deposit loan with a consumer who has an outstanding deferred deposit loan;

(15) renewing, repaying, refinancing, or consolidating a deferred deposit loan with the proceeds of another deferred deposit loan made to the same consumer. However, a licensee may without charge extend the term of the loan beyond the due date.

(16) accepting any collateral for a deferred deposit loan;

(17) charging any interest, fees, or charges other than those specifically authorized by this part, including but not limited to charges for insurance;

(18) threatening to take any action against a consumer that is prohibited by this part or making any misleading or deceptive statements regarding the deferred deposit loan;

(19) making a misrepresentation of a material fact by an applicant in obtaining or attempting to obtain a license;

(20) including any of the following provisions in the loan agreement required by 31-1-721:

(a) a hold harmless clause;

(b) a confession of judgment clause;

(c) a waiver of the right to a jury trial, if applicable, in any action brought by or against a consumer;

(d) any assignment of or order for payment of wages or other compensation for services;

(e) a provision in which the consumer agrees not to assert any claim or defense arising out of the contract; or

(f) a waiver of any provision of this part.

History: En. Sec. 13, Ch. 404, L. 1999; amd. Sec. 8, Ch. 81, L. 2001; amd. Sec. 2, Ch. 210, L. 2005; amd. Sec. 12, Ch. 451, L. 2007.

31-1-724. Civil remedies. (1) The remedies provided in this section are cumulative and apply to licensees and unlicensed persons to whom this part applies.

(2) Any intentional violation of this part constitutes an unfair or deceptive trade practice.

(3) Any person found to have intentionally violated this part is liable to the consumer for actual and consequential damages, plus statutory damages of $1,000 for each violation, plus costs and attorney fees.

(4) A consumer may sue for injunctive and other appropriate equitable relief to stop a person from violating any provisions of this part.

(5) The consumer may bring a class action suit to enforce this part.

(6) The remedies provided in this section are not intended to be the exclusive remedies available to a consumer for a violation of this part.

History: **En. Sec. 14, Ch. 404, L. 1999; amd. Sec. 5, Ch. 221, L. 2003.**

31-1-725. Repealed. Sec. 9, Ch. 23, L. 2015.

History: **En. Sec. 15, Ch. 404, L. 1999.**

31-1-726. Investigations by department — subpoenas — oaths — examination of witnesses and evidence. (1) The department may investigate any matter, upon complaint or otherwise, if it appears that a person has engaged in or offered to engage in any act or practice that is in violation of any provision of this part or any rule adopted or order issued by the department pursuant to this part.

(2) The department may issue subpoenas to compel the attendance of witnesses and the production of documents, papers, books, records, and other evidence before it in any matter over which it has jurisdiction, control, or supervision pertaining to this part. The department may administer oaths and affirmations to a person whose testimony is required.

(3) If a person refuses to obey a subpoena or to give testimony or produce evidence as required by the subpoena, a judge of the district court in the county in which the licensed premises or the person's principal place of business is located or where the person resides may, upon application and proof of the refusal, issue a subpoena or subpoena duces tecum for the witness to appear before the department to give testimony and produce evidence as may be required. The clerk of court shall then issue the subpoena, as directed, under the seal of the court, requiring the person to whom it is directed to appear at the time and place designated in the subpoena.

(4) If a person served with a subpoena refuses to obey the subpoena or to give testimony or produce evidence as required by the subpoena, the department may proceed under the contempt provisions of Title 3, chapter 1, part 5.

(5) Failure to comply with a court-ordered subpoena is punishable pursuant to 45-7-309.

History: **En. Sec. 13, Ch. 451, L. 2007; amd. Sec. 12, Ch. 535, L. 2021.**

31-1-727. Cease and desist orders. (1) If the department determines that a person has engaged in or is about to engage in any act or practice constituting a violation of any provision of this part or any rule adopted or order issued by the department pursuant to this part, the department may issue an order directing the person to cease and desist from continuing the act or practice after issuance and service of a notice as provided in 31-1-712. The order may apply only to the alleged act or practice constituting a violation of this part.

(2) The department may issue a temporary order pending the hearing that:

(a) remains in effect until 14 days after the hearings examiner issues proposed findings of fact and conclusions of law and a proposed order; or

(b) becomes final if the person to whom notice is issued and served as provided in 31-1-712 does not request a hearing within 14 days after the date on which the notice was sent by certified mail.

(3) A violation of an order issued pursuant to this section is subject to the penalty provisions of this part.

History: **En. Sec. 14, Ch. 451, L. 2007; amd. Sec. 3, Ch. 23, L. 2015.**

31-1-728. Injunctions — receivers. (1) Whenever the department has reason to believe that a person is using, has used, or is about to knowingly use any method, act, or practice that violates any provision of this part or any rule adopted or order issued by the department pursuant to this part, the department, upon determining that proceeding would be in the public interest, may bring an action in the name of the state against the person to restrain by temporary or permanent injunction or temporary restraining order the use of the unlawful method, act, or practice.

(2) The notice for an action pursuant to subsection (1) must state generally the relief sought and be served at least 20 days before the hearing of the action in which the relief sought is a temporary or permanent injunction. The notice for a temporary restraining order is governed by 27-19-315.

(3) An action under this section may be brought in the district court in the county in which a person resides or has the person's principal place of business or in the district court of Lewis and Clark County if the person is not a resident of this state or does not maintain a place of business in this state.

(4) A district court may issue temporary or permanent injunctions or temporary restraining orders to restrain and prevent violations of this part, and an injunction must be issued without bond to the department. If the department is successful in obtaining an injunction or restraining order under this section, the department is entitled to an award of reasonable attorney fees and costs.

(5) In addition to all other means provided by law for the enforcement of a restraining order or injunction, the court in which the action is brought may impound and appoint a receiver for the property and business of the defendant, including books, papers, documents, or records pertaining to the property or business, or as much of the property or business as the court considers reasonably necessary to prevent violations of this part. The receiver, when appointed and qualified, has the powers and duties as to custody, collection, administration, winding up, and liquidation of the property and business that are conferred upon the receiver by the court.

History: En. Sec. 15, Ch. 451, L. 2007.

31-1-729. Violation of specified federal laws — rulemaking authority. (1) A violation of any applicable provision of the Truth in Lending Act, 15 U.S.C. 1601, et seq., the Equal Credit Opportunity Act, 15 U.S.C. 1691, et seq., the Fair Credit Reporting Act, 15 U.S.C. 1681, et seq., the Fair Debt Collection Practices Act, 15 U.S.C. 1692, et seq., the Financial Services Modernization Act of 1999 (Gramm-Leach-Bliley Act), 15 U.S.C. 6801, et seq., the USA PATRIOT Act of 2001, as reauthorized, Public Law 107-56, the John Warner National Defense Authorization Act for Fiscal Year 2007, Public Law 109-364, or any regulation promulgated under those acts is also a violation of this part.

(2) The department shall adopt rules to implement this section.

History: En. Sec. 2, Ch. 81, L. 2009.

Part 8
Title Loan Act
(Repealed)

31-1-801. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 1, Ch. 455, L. 2001.

31-1-802. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 2, Ch. 455, L. 2001; amd. Sec. 1, Ch. 178, L. 2003; amd. Sec. 9, Ch. 163, L. 2005; amd. Sec. 2, Ch. 497, L. 2007.

31-1-803. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 3, Ch. 455, L. 2001; amd. Sec. 221(1), Ch. 483, L. 2001; amd. Sec. 2, Ch. 178, L. 2003; amd. Sec. 3, Ch. 497, L. 2007.

31-1-804. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 4, Ch. 455, L. 2001.

31-1-805. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 5, Ch. 455, L. 2001; amd. Sec. 1, Ch. 120, L. 2005; amd. Sec. 3, Ch. 134, L. 2009.

31-1-806 through 31-1-809 reserved.

31-1-810. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 6, Ch. 455, L. 2001; amd. Sec. 4, Ch. 134, L. 2009.

31-1-811. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 7, Ch. 455, L. 2001; amd. Sec. 3, Ch. 178, L. 2003; amd. Sec. 4, Ch. 497, L. 2007.

31-1-812. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 8, Ch. 455, L. 2001.

31-1-813. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 5, Ch. 497, L. 2007.

31-1-814 reserved.

31-1-815. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 9, Ch. 455, L. 2001.

31-1-816. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 10, Ch. 455, L. 2001; amd. Sec. 39, Ch. 477, L. 2003; amd. Sec. 3, Ch. 210, L. 2005; amd. Sec. 8, Ch. 497, L. 2007.

31-1-817. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 11, Ch. 455, L. 2001; amd. Sec. 4, Ch. 178, L. 2003; amd. Sec. 9, Ch. 497, L. 2007; amd. Sec. 7, I.M. No. 164, approved Nov. 2, 2010.

31-1-818. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 12, Ch. 455, L. 2001.

31-1-819. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 13, Ch. 455, L. 2001.

31-1-820. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 14, Ch. 455, L. 2001.

31-1-821. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 15, Ch. 455, L. 2001.

31-1-822. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 16, Ch. 455, L. 2001.

31-1-823 and 31-1-824 reserved.

31-1-825. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 17, Ch. 455, L. 2001; amd. Sec. 5, Ch. 178, L. 2003; amd. Sec. 10, Ch. 497, L. 2007.

31-1-826. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 18, Ch. 455, L. 2001; amd. Sec. 6, Ch. 178, L. 2003.

31-1-827. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 19, Ch. 455, L. 2001.

31-1-828. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 1, Ch. 134, L. 2009.

31-1-829. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 2, Ch. 134, L. 2009.

31-1-830 through 31-1-840 reserved.

31-1-841. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 6, Ch. 497, L. 2007.

31-1-842. Repealed. Sec. 7, Ch. 278, L. 2013.

History: En. Sec. 7, Ch. 497, L. 2007.

CHAPTER 2
DEBTOR AND CREDITOR RELATIONSHIPS

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31-2-341. Termination of cause of action.
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Chapter Cross-References

Imprisonment for debt, Art. II, sec. 27, Mont. Const.
Compromise of debt without seal valid, 1-4-207.
State debt collection service, Title 17, ch. 4, part 1.
Teachers' retirement compensation exempt from taxation and legal process, 19-20-706.
Challenge to jurors for cause — not to be taken for debtor-creditor relationship, 25-7-223.
Duration of judgment — lien — expiration, 25-9-301.
Filing of transcript of judgment — when constitutes lien — expiration, 25-9-302.
Judgment lien of federal court, 25-9-303.
Execution against judgment debtor, Title 25, ch. 13.
Execution — supplementary proceeding — arrest of debtor, Title 25, ch. 14, part 1.

Proceedings against joint debtors, Title 25, ch. 15, part 1.
Judgment lien of Justice's Court, 25-31-914.
Execution of judgment of Justice's Court, Title 25, ch. 31, part 11.
Disputable presumption that obligation delivered to debtor has been paid, 26-1-602.
Remedies in general, Title 27.
Declaratory judgment to ascertain class of creditor, 27-8-204.
Confession of judgment for debt due, 27-9-101.
Extinction of obligation by performance, Title 28, ch. 1, part 11.
Accord and satisfaction, Title 28, ch. 1, part 14.
Novation, Title 28, ch. 1, part 15.
When promise to answer for debt must be in writing, 28-2-903.
Representation of credit by writing, 28-2-903.
Credit extended to agent — exoneration of principal, 28-10-609.
When agent responsible to third persons for credit extended, 28-10-702.
Default — creditors' U.C.C. remedies, Title 30, ch. 9A, part 6.
When factor may sell on credit, 30-11-603.
Plain Language in Contracts Act, Title 30, ch. 14, part 11.
Partner's ability to bind partnership, 35-10-301.
Partner's transferable interest subject to charging order, 35-10-505.
Workers' compensation payment not assignable, 39-71-743.
Liability of spouses for each other's debts, 40-2-106, 40-2-205 through 40-2-210.
Defrauding creditors, 45-6-315.
Deceptive practices, 45-6-317.
Debtor-creditor relationship created by deposit for exchange, 70-6-108.
Creditor may be made party in action for partition of real property, 70-29-105.
Homestead exemption — execution, Title 70, ch. 32, part 2.
Foreclosure of mortgage, 71-1-222 through 71-1-235.
Debtor's misrepresentation of value of pledge, 71-2-110.
Effect of lien on rights of creditor, 71-3-111.
Creditor and purchaser not included in term "distributee" under Uniform Probate Code, 72-1-103.
Creditors' claims against estate, Title 72, ch. 3, part 8.

Part 1
General Provisions — Definitions

31-2-101. Debtor defined. A debtor is one who, by reason of an existing obligation, is or may become liable to pay money to another, whether such liability is certain or contingent.

History: En. Sec. 4480, Civ. C. 1895; re-en. Sec. 6122, Rev. C. 1907; re-en. Sec. 8598, R.C.M. 1921; Cal. Civ. C. Sec. 3429; Field Civ. C. Sec. 1913; re-en. Sec. 8598, R.C.M. 1935; R.C.M. 1947, 18-101.

Cross-References

Proceedings in aid of execution against debtor, Title 25, ch. 14.
Liability of joint debtors, Title 25, ch. 15.
Right to contribution from joint debtors, 28-1-303.
Performance by one of several joint debtors, 28-1-1102.
Release of debtor by creditor, Title 28, ch. 1, part 16.
Irrigation district — refusal of water to debtor, 85-7-1902.

31-2-102. Creditor defined. A creditor is a person in whose favor an obligation exists, by reason of which the person is or may become entitled to the payment of money.

History: En. Sec. 4481, Civ. C. 1895; re-en. Sec. 6123, Rev. C. 1907; re-en. Sec. 8599, R.C.M. 1921; Cal. Civ. C. Sec. 3430; Field Civ. C. Sec. 1914; re-en. Sec. 8599, R.C.M. 1935; R.C.M. 1947, 18-102; amd. Sec. 981, Ch. 56, L. 2009.

Cross-References

Performance to one of several joint creditors, 28-1-1103.
Extinction when directions of creditor followed, 28-1-1104.
Release of debtor by creditor, Title 28, ch. 1, part 16.
U.C.C. — creditor defined, 30-1-201.

31-2-103. Contracts of debtor are valid. In the absence of fraud, every contract of a debtor is valid against all the debtor's creditors, existing or subsequent, who have not acquired a lien on the property affected by the contract.

History: En. Sec. 4482, Civ. C. 1895; re-en. Sec. 6124, Rev. C. 1907; re-en. Sec. 8600, R.C.M. 1921; Cal. Civ. C. Sec. 3431; Field Civ. C. Sec. 1915; re-en. Sec. 8600, R.C.M. 1935; R.C.M. 1947, 18-103; amd. Sec. 982, Ch. 56, L. 2009.

Cross-References

Who may contract, 28-2-201.
Kinds of contract fraud, 28-2-404 through 28-2-406.
Liens, Title 71, ch. 3.

31-2-104. Payments in preference. A debtor may pay one creditor in preference to another or may give to one creditor security for the payment of the creditor's demand in preference to another.

History: En. Sec. 4483, Civ. C. 1895; re-en. Sec. 6125, Rev. C. 1907; re-en. Sec. 8601, R.C.M. 1921; Cal. Civ. C. Sec. 3432; Field Civ. C. Sec. 1916; re-en. Sec. 8601, R.C.M. 1935; R.C.M. 1947, 18-104; amd. Sec. 983, Ch. 56, L. 2009.

Cross-References

Performance to one of several joint creditors, 28-1-1103.
Extinction when directions of creditor followed, 28-1-1104.
U.C.C. — security interest defined, 30-1-201.
U.C.C. — perfection and priority of security interests, Title 30, ch. 9A, part 3.
Preference given for wages, 31-2-205.
Preference to be absolute, 31-2-206.
Certain rights not affected by preferences in assignment, 31-2-207.

31-2-105. Relative rights of different creditors. When a creditor is entitled to resort to each of several funds for the satisfaction of the creditor's claim and another person has an interest in or is entitled as a creditor to resort to some but not all of the funds, the the other person may require the creditor to seek satisfaction from those funds to which the other person does not have a claim so far as it can be done without impairing the right of the creditor to complete satisfaction and without doing injustice to third persons.

History: En. Sec. 4484, Civ. C. 1895; re-en. Sec. 6126, Rev. C. 1907; re-en. Sec. 8602, R.C.M. 1921; Cal. Civ. C. Sec. 3433; Field Civ. C. Sec. 1917; re-en. Sec. 8602, R.C.M. 1935; R.C.M. 1947, 18-105; amd. Sec. 984, Ch. 56, L. 2009.

Cross-References

Performance to one of several joint creditors, 28-1-1103.
U.C.C. — security interests — perfection and priority, Title 30, ch. 9A, part 3.

31-2-106. Exempt property — bankruptcy proceeding. An individual may not exempt from the property of the estate in any bankruptcy proceeding the property specified in 11 U.S.C. 522(d). An individual may exempt from the property of the estate in any bankruptcy proceeding:

(1) that property exempt from execution of judgment as provided in 19-2-1004, 19-18-612, 19-19-504, 19-20-706, 19-21-212, Title 25, chapter 13, part 6, 33-7-522, 33-15-512 through 33-15-514, 39-51-3105, 39-71-743, 39-73-110, 53-2-607, 53-9-129, Title 70, chapter 32, and 80-2-245;

(2) medical care, health, and medical savings accounts as provided in 25-13-603;

(3) the individual's right to receive unemployment compensation and unemployment benefits; and

(4) the individual's right to receive benefits from or interest in a private or governmental retirement, pension, stock bonus, profit-sharing, annuity, or similar plan or contract on account of illness, disability, death, age, or length of service, excluding that portion of contributions made by the individual within 1 year before the filing of the petition in bankruptcy that exceeds 15% of the individual's gross income for that 1-year period, unless:

(a) the plan or contract was established by or under the auspices of an insider that employed the individual at the time the individual's rights under the plan or contract arose;

(b) the benefit is paid on account of age or length of service; and

(c) the plan or contract does not qualify under section 401(a), 403(a), 403(b), 408, or 409 of the Internal Revenue Code, 26 U.S.C. 401(a), 403(a), 403(b), 408, or 409.

History: En. Sec. 1, Ch. 161, L. 1981; amd. Sec. 1, Ch. 208, L. 1987; amd. Sec. 1, Ch. 45, L. 1989; amd. Sec. 1, Ch. 301, L. 1989; amd. Sec. 39, Ch. 586, L. 1991; amd. Sec. 59, Ch. 238, L. 1993; amd. Sec. 234, Ch. 265, L. 1993; amd. Sec. 71, Ch. 114, L. 2003; amd. Sec. 52, Ch. 2, L. 2009; amd. Sec. 4, Ch. 298, L. 2017.

Part 2
Assignments for Benefit of Creditors

Part Cross-References

Transfer of rights and duties under obligation, Title 28, ch. 1, part 10.
Transfer in trust for benefit of creditors to be recorded, 70-21-202.

31-2-201. When debtor may execute assignment. An insolvent debtor may, in good faith, execute an assignment of property to one or more assignees in trust for the satisfaction of the debtor's creditors, in conformity with the provisions of this part, subject to the provisions of this code relative to trusts and fraudulent transfers and to the restrictions imposed by law upon assignments by special partnerships, corporations, or other specific classes or persons.

History: En. Sec. 4510, Civ. C. 1895; re-en. Sec. 6136, Rev. C. 1907; re-en. Sec. 8612, R.C.M. 1921; Cal. Civ. C. Sec. 3449; Field Civ. C. Sec. 1924; re-en. Sec. 8612, R.C.M. 1935; R.C.M. 1947, 18-301; amd. Sec. 985, Ch. 56, L. 2009.

Cross-References

Trust Code, Title 72, ch. 38.

31-2-202. Insolvency — what constitutes. A debtor is insolvent, within the meaning of this part, when the debtor is unable to pay the debtor's debts from the debtor's own means as they become due.

History: En. Sec. 4511, Civ. C. 1895; re-en. Sec. 6137, Rev. C. 1907; re-en. Sec. 8613, R.C.M. 1921; Cal. Civ. C. Sec. 3450; Field Civ. C. Sec. 1925; re-en. Sec. 8613, R.C.M. 1935; R.C.M. 1947, 18-302; amd. Sec. 986, Ch. 56, L. 2009.

Cross-References

U.C.C. — insolvent defined, 30-1-201.

31-2-203. Certain transfers not affected. The provisions of this part do not prevent a person residing in another state or country from making there, in good faith and without intent to evade the laws of this state, a transfer of property situated within the other state or territory. This part does not affect the power of a person, although insolvent and within this state, to transfer property to a particular creditor for the purpose of paying or securing the whole or a part of a debt owing to the creditor, whether in the person's own right or otherwise.

History: En. Sec. 4512, Civ. C. 1895; re-en. Sec. 6138, Rev. C. 1907; re-en. Sec. 8614, R.C.M. 1921; Cal. Civ. C. Sec. 3451; Field Civ. C. Sec. 1926; re-en. Sec. 8614, R.C.M. 1935; R.C.M. 1947, 18-303; amd. Sec. 987, Ch. 56, L. 2009.

31-2-204. What debts may be secured. An assignment for the benefit of creditors may provide for any subsisting liability of the assignor that the assignor might lawfully pay, whether absolute or contingent.

History: En. Sec. 4513, Civ. C. 1895; re-en. Sec. 6139, Rev. C. 1907; re-en. Sec. 8615, R.C.M. 1921; Cal. Civ. C. Sec. 3452; Field Civ. C. Sec. 1927; re-en. Sec. 8615, R.C.M. 1935; R.C.M. 1947, 18-304; amd. Sec. 988, Ch. 56, L. 2009.

31-2-205. Preference given for wages. In all assignments of property made by any person, association, partnership, chartered company, or corporation to trustees or assignees on account of inability of the assignor at the time of the assignment to pay the assignor's debts or in proceedings in insolvency, the wages of the miners, mechanics, salespersons, servants, clerks, or laborers employed by the assignor for services rendered within 4 months immediately previous to the assignment, not to exceed the actual amount owed for each person, are preferred claims and must be paid by the trustees or assignees before any other creditor of the assignor.

History: En. Sec. 2050, 5th Div. Comp. Stat. 1887; re-en. Sec. 4514, Civ. C. 1895; re-en. Sec. 6140, Rev. C. 1907; re-en. Sec. 8616, R.C.M. 1921; re-en. Sec. 8616, R.C.M. 1935; amd. Sec. 6, Ch. 109, L. 1943; R.C.M 1947, 18-305; amd. Sec. 989, Ch. 56, L. 2009.

Cross-References

Payments in preference, 31-2-104.

Priority when assignment of property made, 71-3-301.

31-2-206. Preference to be absolute. A preference in an assignment for the benefit of creditors can only be given absolutely and without reserving any power of revocation.

History: En. Sec. 4515, Civ. C. 1895; re-en. Sec. 6141, Rev. C. 1907; re-en. Sec. 8617, R.C.M. 1921; Field Civ. C. Sec. 1929; re-en. Sec. 8617, R.C.M. 1935; R.C.M. 1947, 18-306.

Cross-References

Payments in preference, 31-2-104.

31-2-207. Certain rights not affected by preferences in assignment. No provision in an assignment giving a preference to a creditor can affect or impair any right of another creditor to priority of payment, whether created by law or arising from an obligation or transaction of the parties.

History: En. Sec. 4516, Civ. C. 1895; re-en. Sec. 6142, Rev. C. 1907; re-en. Sec. 8618, R.C.M. 1921; Field Civ. C. Sec. 1930; re-en. Sec. 8618, R.C.M. 1935; R.C.M. 1947, 18-307.

Cross-References

Payments in preference, 31-2-104.

Priority when assignment of property made, 71-3-301.

31-2-208. Joint and separate debts. Joint or joint and several debtors can prefer their joint creditors only out of joint property and can prefer the individual creditors of each only out of the separate property of each.

History: En. Sec. 4517, Civ. C. 1895; re-en. Sec. 6143, Rev. C. 1907; re-en. Sec. 8619, R.C.M. 1921; Field Civ. C. Sec. 1931; re-en. Sec. 8619, R.C.M. 1935; R.C.M. 1947, 18-308.

Cross-References

Liability of joint debtors, Title 25, ch. 15.
Joint obligations, Title 28, ch. 1, part 3.

31-2-209. Assignment — when void. An assignment for the benefit of creditors is void against any creditor of the assignor not assenting to the assignment in the following cases:

(1) if the assignment gives a preference dependent upon any condition or contingency or with any power of revocation reserved;

(2) if the assignment tends to coerce any creditor to release or compromise the creditor's demand;

(3) if the assignment provides for the payment of any claim known by the assignor to be false or fraudulent or for the payment of more upon any claim than is known to be justly due from the assignor;

(4) if the assignment reserves any interest in the assigned property or in any part of the property to the assignor or for the assignor's benefit before all existing debts are paid;

(5) if the assignment confers upon the assignee any power that, if exercised, might prevent or delay the immediate conversion of the assigned property to the purposes of the trust;

(6) if the assignment exempts the assignor from liability for neglect of duty or misconduct.

History: En. Sec. 4518, Civ. C. 1895; re-en. Sec. 6144, Rev. C. 1907; re-en. Sec. 8620, R.C.M. 1921; Cal. Civ. C. Sec. 3457; Based on Field Civ. C. Sec. 1932; re-en. Sec. 8620, R.C.M. 1935; R.C.M. 1947, 18-309; amd. Sec. 217, Ch. 685, L. 1989; amd. Sec. 990, Ch. 56, L. 2009; amd. Sec. 142, Ch. 264, L. 2013.

Cross-References

Transfer of rights and duties under obligation, Title 28, ch. 1, part 10.
Contracts that violate policy of law — exemption from responsibility, 28-2-702.

31-2-210. The instrument of assignment. (1) An assignment for the benefit of creditors must be in writing and subscribed by the assignor or by the assignor's agent authorized by writing.

(2) The assignment must be acknowledged or proved and certified in the mode prescribed by the law on recording transfers of real property and recorded as required by 31-2-215 and 31-2-216, but recording in one county constitutes a compliance with 31-2-215 and 31-2-216.

(3) The assignment must be accompanied by the affidavit of the assignor and assignee that the assignment is made in good faith, for the benefit of the creditors of the assignor, and without any design to hinder, delay, or defraud the creditors.

(4) The assent of the assignee, subscribed and acknowledged by the assignee, must appear in writing contained in or at the end of or endorsed upon the assignment before the assignment is recorded and, if separate from the assignment, must be duly acknowledged.

History: En. Sec. 4519, Civ. C. 1895; re-en. Sec. 6145, Rev. C. 1907; re-en. Sec. 8621, R.C.M. 1921; Cal. Civ. C. Sec. 3458; Based on Field Civ. C. Sec. 1933; re-en. Sec. 8621, R.C.M. 1935; R.C.M. 1947, 18-310; amd. Sec. 991, Ch. 56, L. 2009.

Cross-References

Real property acknowledgment of transfer, 3-1-404.
Certificate of acknowledgment of transfer, 3-1-405.
What contracts must be in writing, 28-2-903.
What acts agent may perform, 28-10-105.
Agency — when written authorization necessary, 28-10-203.
U.C.C. — good faith defined, 30-1-201, 30-2-103.
Recording of mortgages and assignments, 71-1-207.

31-2-211. Compliance necessary to validity of assignment. Unless the provisions of 31-2-210 are complied with, an assignment for the benefit of creditors is void against every creditor of the assignor not assenting thereto.

History: En. Sec. 4520, Civ. C. 1895; re-en. Sec. 6146, Rev. C. 1907; re-en. Sec. 8622, R.C.M. 1921; Cal. Civ. C. Sec. 3459; Field Civ. C. Sec. 1934; re-en. Sec. 8622, R.C.M. 1935; R.C.M. 1947, 18-311.

Cross-References

When contract wholly void, 28-2-603.
When contract partially void, 28-2-604.
Contracts — what conditions void, 28-2-707.

31-2-212. Assignee takes subject to rights of third parties. An assignee for the benefit of creditors is not to be regarded as a purchaser for value and has no greater rights than the assignor has in respect to things in action transferred by the assignment.

History: En. Sec. 4521, Civ. C. 1895; re-en. Sec. 6147, Rev. C. 1907; re-en. Sec. 8623, R.C.M. 1921; Cal. Civ. C. Sec. 3460; Field Civ. C. Sec. 1935; re-en. Sec. 8623, R.C.M. 1935; R.C.M. 1947, 18-312; amd. Sec. 992, Ch. 56, L. 2009.

Cross-References

What defenses to action survive assignment of right to action, 27-1-503.

31-2-213. Inventory required. Within 20 days after an assignment is made for the benefit of creditors, the assignor must make and file, in the manner prescribed by 31-2-215, a full and true inventory showing:

(1) all the creditors of the assignor;

(2) the place of residence of each creditor, if known to the assignor, or if not known, that fact must be stated;

(3) the sum owing to each creditor and the nature of each debt or liability, whether arising on written security, account, or otherwise;

(4) the true consideration of the liability in each case and the place where it arose;

(5) every existing judgment, mortgage, or other security for the payment of any debt or liability of the assignor;

(6) all property of the assignor at the date of the assignment which is exempt by law from execution; and

(7) all of the assignor's property at the date of the assignment, both real and personal, of every kind, not so exempt; the encumbrances existing thereon; all vouchers and securities relating thereto; and the value of such property, according to the best knowledge of the assignor.

History: En. Sec. 4522, Civ. C. 1895; re-en. Sec. 6148, Rev. C. 1907; re-en. Sec. 8624, R.C.M. 1921; Cal. Civ. C. Sec. 3461; Field Civ. C. Sec. 1936; re-en. Sec. 8624, R.C.M. 1935; R.C.M. 1947, 18-313.

Cross-References

Rules for determining residence, 1-1-215.
Property exempt from execution, Title 25, ch. 13, part 6.
Proceedings to determine availability of property for execution, Title 25, ch. 14, part 1.
Contracts — consideration, Title 28, ch. 2, part 8.
U.C.C. — effectiveness of security agreement, Title 30, ch. 9A, part 2.
Homestead exemption, Title 70, ch. 32, part 2.

31-2-214. Verification of inventory — when assignee required to file — inspection of assignor's books and papers. (1) An affidavit must be made by every person executing an assignment for the benefit of creditors, to be annexed to and filed with the inventory mentioned in 31-2-213, to the effect that the affidavit is in all respects just and true according to the best of the assignor's knowledge and belief.

(2) (a) If the assignor omits, neglects, or refuses to make and deliver the inventory within the required 20 days, the assignee named in the assignment shall, within 30 days after the required date, cause to be made and delivered to the judge of the district court of the county where the assignment is recorded the inventory as described in subsection (1), insofar as the assignee can.

(b) For the purpose of subsection (2)(a), the judge shall, at any time upon the application of the assignee, compel by order the delinquent assignor and any other person to appear before the judge and disclose, upon oath, any knowledge or information the assignor or person may possess necessary to the proper making of the inventory.

(c) The assignee shall verify the inventory made by the assignee to the effect that the inventory is in all respects just and true to the best of the assignee's knowledge and belief.

(3) If the assignee is unable to make and file the inventory within 30 days, the district judge may, upon application upon oath showing the inability, allow the assignee further time as necessary, not exceeding 60 days.

(4) If the assignee fails to make and file the inventory within 30 days or the further time that may be allowed, the district judge shall require, by order, the assignee to appear before the judge and show cause why the assignee should not be removed. Any person interested in the trust estate may apply for the order and demand the removal.

(5) The books and papers of the delinquent assignor must at all times be subject to the inspection and examination of any creditor. The district judge is authorized by order to require the debtor or assignee to allow the inspection or examination. Disobedience to an inspection order is a contempt, and obedience to the order may be enforced by attachment.

(6) The inventory must be filed by the district judge in the office of the clerk of the county in which the assignment is recorded.

History: En. Sec. 4523, Civ. C. 1895; re-en. Sec. 6149, Rev. C. 1907; re-en. Sec. 8625, R.C.M. 1921; Cal. Civ. C. Sec. 3462; re-en. Sec. 8625, R.C.M. 1935; R.C.M. 1947, 18-314; amd. Sec. 993, Ch. 56, L. 2009.

Cross-References

Role and duties of County Clerk and Election Administrator, 7-4-2611.
Affidavits, Title 26, ch. 1, part 10.

31-2-215. Recording assignment and filing inventory. An assignment for the benefit of creditors must be recorded and the inventory required by 31-2-213 must be filed with the county clerk of the county in which the assignor resided at the date of the assignment or, if the assignor did not reside in this state at that time, with the clerk of the county in which the assignor's principal place of business was situated or, if the assignor did not have a residence or place of business in this state, with the clerk of the county in which the principal part of the assigned property was situated at the time of the assignment.

History: En. Sec. 4524, Civ. C. 1895; re-en. Sec. 6150, Rev. C. 1907; re-en. Sec. 8626, R.C.M. 1921; Cal. Civ. C. Sec. 3463; Based on Field Civ. C. Sec. 1938; re-en. Sec. 8626, R.C.M. 1935; R.C.M. 1947, 18-315; amd. Sec. 994, Ch. 56, L. 2009.

Cross-References

Rules for determining residence, 1-1-215.
Role and duties of County Clerk and Election Administrator, 7-4-2611.

31-2-216. Recording and filing when more than one assignor. If an assignment for the benefit of creditors is executed by more than one assignor, it must be recorded and a copy of the inventory required by 31-2-213 must be filed with the county clerk of the county in which any of the assignors resided at its date or in which any of them not then residing in this state then had a place of business.

History: En. Sec. 4525, Civ. C. 1895; re-en. Sec. 6151, Rev. C. 1907; re-en. Sec. 8627, R.C.M. 1921; Cal. Civ. C. Sec. 3464; Based on Field Civ. C. Sec. 1939; re-en. Sec. 8627, R.C.M. 1935; R.C.M. 1947, 18-316.

Cross-References

Rules for determining residence, 1-1-215.
Role and duties of County Clerk and Election Administrator, 7-4-2611.

31-2-217. Effect of failing to record. An assignment for the benefit of creditors is void against creditors of the assignor and against purchasers and encumbrances in good faith and for value unless it is recorded within 20 days after the date of the assignment.

History: En. Sec. 4526, Civ. C. 1895; re-en. Sec. 6152, Rev. C. 1907; re-en. Sec. 8628, R.C.M. 1921; Cal. Civ. C. Sec. 3465; Based on Field Civ. C. Sec. 1940; re-en. Sec. 8628, R.C.M. 1935; R.C.M. 1947, 18-317.

31-2-218. Assignment of real property. When an assignment for the benefit of creditors embraces real property, it is subject to the provisions of this part, 70-21-102, and Title 70, chapter 21, part 3.

History: En. Sec. 4527, Civ. C. 1895; re-en. Sec. 6153, Rev. C. 1907; re-en. Sec. 8629, R.C.M. 1921; Cal. Civ. C. Sec. 3466; Field Civ. C. Sec. 1941; re-en. Sec. 8629, R.C.M. 1935; amd. Sec. 1, Ch. 185, L. 1977; R.C.M. 1947, 18-318; amd. Sec. 4, Ch. 88, L. 1979.

31-2-219. Bond of assignees. Within 30 days after the date of an assignment for the benefit of creditors, the assignee must enter into a bond to the state, for the use and benefit of the creditors, in such amount as may be fixed by a judge of the district court of the county in which the original inventory is filed, with sufficient sureties to be approved by such judge, and conditioned for the faithful discharge of the trust and the due accounting for all moneys received by the assignee, which bond must be filed in the same office with the original inventory.

History: En. Sec. 4528, Civ. C. 1895; re-en. Sec. 6154, Rev. C. 1907; re-en. Sec. 8630, R.C.M. 1921; Cal. Civ. C. Sec. 3467; Based on Field Civ. C. Sec. 1942; re-en. Sec. 8630, R.C.M. 1935; R.C.M. 1947, 18-319.

Cross-References

Role and duties of County Clerk and Election Administrator, 7-4-2611.
Suretyship, Title 28, ch. 11, part 4.
Surety insurance, Title 33, ch. 26, part 1.

31-2-220. Management, disposal, and conversion of estate. (1) Until the inventory and affidavit required by 31-2-213 and 31-2-214 have been made and filed and the assignee has given bond as required by 31-2-219, the assignee for the benefit of creditors has no authority to dispose of the estate or convert it to the purposes of the trust.

(2) However, if the assignor fails to present the inventory within the required 20 days, then the assignee, before the 10 days have elapsed, may apply to the district judge by verified petition for leave to file a provisional bond until the time that the assignor may be able to present the inventory as provided in this section.

(3) The district judge shall, in the case described in 31-2-214, and may also at any time on the petition of one or more creditors showing misconduct or incompetency of the assignee or on petition of the assignee, showing sufficient reason, and after due notice of not less than 5 days to the assignor, assignee, surety, and other persons that the judge may prescribe:

(a) remove or discharge the assignee and appoint one or more assignees in the former assignee's place; and

(b) order an accounting of the assignee removed or discharged.

(4) The district judge may:

(a) enjoin the assignee from interfering with the assignor's estate and make provision by order for the safe custody of the estate; and

(b) enforce obedience to the injunction and orders by attachment.

(5) Upon discharge, upon the former assignee's application, the former assignee's bond must be canceled and discharged.

(6) The new assignee shall give a bond, which must be approved as required.

(7) The district judge has power by order to:

(a) require or allow any inventory or schedule filed to be corrected or amended;

(b) require and compel, from time to time, supplemental inventories or schedules to be made and filed within the time that the judge prescribes; and

(c) enforce obedience to the orders by attachment.

History: **En. Sec. 4529, Civ. C. 1895; re-en. Sec. 6155, Rev. C. 1907; amd. Sec. 1, Ch. 180, L. 1919; amd. Sec. 1, Ch. 215, L. 1921; re-en. Sec. 8631, R.C.M. 1921; Cal. Civ. C. Sec. 3468; re-en. Sec. 8631, R.C.M. 1935; R.C.M. 1947, 18-320; amd. Sec. 995, Ch. 56, L. 2009.**

Cross-References

Prejudgment attachment, Title 27, ch. 18.
Injunctions, Title 27, ch. 19.
Suretyship, Title 28, ch. 11, part 4.

31-2-221. Notice to creditors to present claims. (1) The judge may, upon the petition of the assignee, authorize the assignee to advertise for creditors to present to the assignee their claims, with the vouchers for the claims, duly verified, on or before a day to be specified in the advertisement, not less than 10 days from the publication. The advertisement or notice must be published in one newspaper, to be designated by the judge as most likely to give notice to the persons to be served, at least once and any additional times that the judge may direct. The last publication must be at least 1 week prior to the date specified.

(2) The verified claims of creditors must set forth whether any and, if so, what securities are held for the claims and whether any and, if so, what payments have been made on the claims.

History: **En. Sec. 1, Ch. 180, L. 1919; amd. Sec. 1, Ch. 215, L. 1921; re-en. Sec. 8632, R.C.M. 1921; re-en. Sec. 8632, R.C.M. 1935; R.C.M. 1947, 18-321; amd. Sec. 996, Ch. 56, L. 2009.**

Cross-References

Legal notice by publication, Title 18, ch. 7, part 2.

31-2-222. Notices to parties interested in the estate as creditors or otherwise. (1) Parties interested in the estate as creditors or parties otherwise interested, if the judge so directs, shall have at least 10 days' notice by mail to their respective addresses as they appear in the schedule filed by the assignor, or at such other addresses as they shall have filed with the assignee, of:

(a) all proposed sales of property, in bulk;

(b) the filing of the final account of the assignee and of the hearing thereon;

(c) any proposed compromise with creditors.

(2) Such notice may be given as the judge shall direct and must be returnable in court, or before the judge of the court at chambers, in the district.

History: **En. Sec. 1, Ch. 180, L. 1919; amd. Sec. 1, Ch. 215, L. 1921; re-en. Sec. 8633, R.C.M. 1921; re-en. Sec. 8633, R.C.M. 1935; R.C.M. 1947, 18-322.**

31-2-223. Duties of assignee. It shall be the duty of the assignee to:

(1) collect and reduce to money the property of the estate and close up the estate as expeditiously as possible;

(2) sell the property of the estate as soon as practicable and sell the accounts and bills receivable when deemed advisable;

(3) furnish such information concerning the estate as may be requested by parties in interest;

(4) keep regular accounts and pay dividends as often as is compatible with the best interests of the estate;

(5) file a final report and account at least 10 days before the hearing thereon.

History: **En. Sec. 1, Ch. 180, L. 1919; amd. Sec. 1, Ch. 215, L. 1921; re-en. Sec. 8634, R.C.M. 1921; re-en. Sec. 8634, R.C.M. 1935; R.C.M. 1947, 18-323.**

31-2-224. Power of court. The court has power to:

(1) authorize the business of the assignor to be conducted for a limited period by assignee, if necessary in the best interests of the estate, and allow additional compensation for the services;

(2) reopen estates when it appears they were closed before being fully administered and for that purpose to appoint another assignee who will take title to the property not administered;

(3) direct upon the final settlement of the estate that the assignee pay to the lawful creditors their proportionate dividend, notwithstanding that their claim has not been presented in accordance with the notice sent out by the assignee, provided that 4 months have not elapsed since the first publication of notice to creditors;

(4) approve the final report and discharge the assignee and the assignee's surety from all further liabilities upon matters included in the accounting to creditors appearing and to creditors not having appeared after due citation or not having presented their claims after due advertisement.

History: **En. Sec. 1, Ch. 180, L. 1919; amd. Sec. 1, Ch. 215, L. 1921; re-en. Sec. 8635, R.C.M. 1921; re-en. Sec. 8635, R.C.M. 1935; R.C.M. 1947, 18-324; amd. Sec. 5, Ch. 88, L. 1979; amd. Sec. 997, Ch. 56, L. 2009.**

31-2-225. When further security required. The district judge may, upon the judge's own motion or upon the application of any party in interest and on notice that the judge may direct to be given to the assignor, assignee, and surety, require further security to be given whenever, in the judge's judgment, the security afforded by the bond on file is not adequate.

History: **En. Sec. 4530, Civ. C. 1895; re-en. Sec. 6156, Rev. C. 1907; re-en. Sec. 8636, R.C.M. 1921; re-en. Sec. 8636, R.C.M. 1935; R.C.M. 1947, 18-325; amd. Sec. 998, Ch. 56, L. 2009.**

Cross-References

Suretyship, Title 28, ch. 11, part 4.

31-2-226. Accounting of assignee. After 6 months from the date of an assignment for the benefit of creditors, the assignee may be required, on petition of any creditor, to make an accounting before the district court of the county where the accompanying inventory was filed.

History: **En. Sec. 4531, Civ. C. 1895; re-en. Sec. 6157, Rev. C. 1907; re-en. Sec. 8637, R.C.M. 1921; Cal. Civ. C. Sec. 3469; Based on Field Civ. C. Sec. 1944; re-en. Sec. 8637, R.C.M. 1935; R.C.M. 1947, 18-326; amd. Sec. 6, Ch. 88, L. 1979.**

31-2-227. Property exempt. Property exempt from execution and insurance upon the life of the assignor do not pass to the assignee by a general assignment for the benefit of creditors unless the instrument specially mentions them and declares an intention that they should pass thereby.

History: **En. Sec. 4532, Civ. C. 1895; re-en. Sec. 6158, Rev. C. 1907; re-en. Sec. 8638, R.C.M. 1921; Cal. Civ. C. Sec. 3470; Field Civ. C. Sec. 1945; re-en. Sec. 8638, R.C.M. 1935; R.C.M. 1947, 18-327.**

Cross-References

Property exempt from execution, Title 25, ch. 13, part 6.
Life insurance, Title 33, ch. 20.
Homestead exemption, Title 70, ch. 32, part 2.

31-2-228. Compensation. In the absence of any provision in the assignment to the contrary, an assignee for the benefit of creditors is entitled to the same commissions as are allowed by law to executors and guardians, but the assignment cannot grant more and may restrict the commissions to a lesser amount or deny them altogether.

History: En. Sec. 4533, Civ. C. 1895; re-en. Sec. 6159, Rev. C. 1907; re-en. Sec. 8639, R.C.M. 1921; Cal. Civ. C. Sec. 3471; Field Civ. C. Sec. 1946; re-en. Sec. 8639, R.C.M. 1935; R.C.M. 1947, 18-328.

Cross-References

Compensation of personal representative, 72-3-631.
Compensation of guardians, 72-5-432.

31-2-229. Assignees protected for acts done in good faith. An assignee for the benefit of creditors may not be held liable for acts done in good faith in the execution of the trust merely for the reason that the assignment is afterwards adjudged void.

History: En. Sec. 4534, Civ. C. 1895; re-en. Sec. 6160, Rev. C. 1907; re-en. Sec. 8640, R.C.M. 1921; Cal. Civ. C. Sec. 3472; Field Civ. C. Sec. 1947; re-en. Sec. 8640, R.C.M. 1935; R.C.M. 1947, 18-329; amd. Sec. 999, Ch. 56, L. 2009.

Cross-References

U.C.C. — good faith defined, 30-1-201, 30-2-103.
U.C.C. — obligation of good faith, 30-1-203.

31-2-230. Assent of creditors necessary to modification of assignment. An assignment for the benefit of creditors which has been executed and recorded so as to transfer the property to the assignee cannot afterwards be canceled or modified by the parties thereto without the consent of every creditor affected thereby.

History: En. Sec. 4535, Civ. C. 1895; re-en. Sec. 6161, Rev. C. 1907; re-en. Sec. 8641, R.C.M. 1921; Cal. Civ. C. Sec. 3473; Field Civ. C. Sec. 1948; re-en. Sec. 8641, R.C.M. 1935; R.C.M. 1947, 18-330.

Part 3
Uniform Fraudulent Transfer Act

Part Cross-References

Claim and delivery of personal property, Title 27, ch. 17.
Kinds of contract fraud, 28-2-404 through 28-2-406.
Defrauding creditors, 45-6-315.
Real property — fraudulent conveyances, Title 70, ch. 20, part 4.

31-2-301. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 1, Ch. 126, L. 1945; R.C.M. 1947, 29-101.

31-2-302. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 2, Ch. 126, L. 1945; R.C.M. 1947, 29-102.

31-2-303. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 3, Ch. 126, L. 1945; R.C.M. 1947, 29-103.

31-2-304 through 31-2-310 reserved.

31-2-311. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 4, Ch. 126, L. 1945; R.C.M. 1947, 29-104.

31-2-312. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 5, Ch. 126, L. 1945; R.C.M. 1947, 29-105.

31-2-313. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 6, Ch. 126, L. 1945; R.C.M. 1947, 29-106.

31-2-314. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 7, Ch. 126, L. 1945; R.C.M. 1947, 29-107.

31-2-315. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 4491, Civ. C. 1895; re-en. Sec. 6128, Rev. C. 1907; re-en. Sec. 8604, R.C.M. 1921; Cal. Civ. C. Sec. 3440; Field Civ. C. Sec. 1919; re-en. Sec. 8604, R.C.M. 1935; amd. Sec. 5, Ch. 185, L. 1977; R.C.M. 1947, 29-208.

31-2-316. Repealed. Sec. 14, Ch. 324, L. 1991.

History: En. Sec. 4493, Civ. C. 1895; re-en. Sec. 6130, Rev. C. 1907; re-en. Sec. 8606, R.C.M. 1921; Cal. Civ. C. Sec. 3442; Field Civ. C. Sec. 1923; re-en. Sec. 8606, R.C.M. 1935; R.C.M. 1947, 29-210.

31-2-317. Repealed. Sec. 14, Ch. 324, L. 1991.
History: En. Sec. 8, Ch. 126, L. 1945; R.C.M. 1947, 29-108.

31-2-318 through 31-2-320 reserved.

31-2-321. Repealed. Sec. 14, Ch. 324, L. 1991.
History: En. Sec. 9, Ch. 126, L. 1945; R.C.M. 1947, 29-109.

31-2-322. Repealed. Sec. 14, Ch. 324, L. 1991.
History: En. Sec. 10, Ch. 126, L. 1945; R.C.M. 1947, 29-110.

31-2-323. Repealed. Sec. 14, Ch. 324, L. 1991.
History: En. Sec. 4492, Civ. C. 1895; re-en. Sec. 6129, Rev. C. 1907; re-en. Sec. 8605, R.C.M. 1921; Cal. Civ. C. Sec. 3441; Field Civ. C. Sec. 1922; re-en. Sec. 8605, R.C.M. 1935; R.C.M. 1947, 29-209.

31-2-324. Repealed. Sec. 14, Ch. 324, L. 1991.
History: En. Sec. 11, Ch. 126, L. 1945; R.C.M. 1947, 29-111.

31-2-325. Repealed. Sec. 14, Ch. 324, L. 1991.
History: En. Sec. 12, Ch. 126, L. 1945; R.C.M. 1947, 29-112.

31-2-326. Short title. This part may be cited as the "Uniform Fraudulent Transfer Act".
History: En. Sec. 1, Ch. 324, L. 1991.

31-2-327. Uniformity of application and construction. This part must be applied and construed to effectuate the general purpose of making uniform the law with respect to the subject of this part among states enacting it.
History: En. Sec. 12, Ch. 324, L. 1991.

31-2-328. Definitions. As used in this part, the following definitions apply:

(1) "Affiliate" means:

(a) a person who directly or indirectly owns, controls, or holds with power to vote 20% or more of the outstanding voting securities of the debtor, other than a person who holds the securities:

(i) as a fiduciary or agent without sole discretionary power to vote the securities; or

(ii) solely to secure a debt if the person has not exercised the power to vote;

(b) a corporation 20% or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote by the debtor or a person who directly or indirectly owns, controls, or holds with power to vote 20% or more of the outstanding voting securities of the debtor, other than a person who holds the securities:

(i) as a fiduciary or agent without sole power to vote the securities; or

(ii) solely to secure a debt if the person has not exercised the power to vote;

(c) a person whose business is operated by the debtor under a lease or other agreement or a person substantially all of whose assets are controlled by the debtor; or

(d) a person who operates the debtor's business under a lease or other agreement or controls substantially all of the debtor's assets.

(2) "Asset" means property of a debtor, but the term does not include:

(a) property to the extent it is encumbered by a valid lien;

(b) property to the extent it is generally exempt under nonbankruptcy law; or

(c) an interest in property held in tenancy by the entireties to the extent it is not subject to process by a creditor holding a claim against only one tenant.

(3) "Claim" means a right to payment, whether or not the right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, legal, equitable, secured, or unsecured.

(4) "Creditor" means a person who has a claim.

(5) "Debt" means liability on a claim.

(6) "Debtor" means a person who is liable on a claim.

(7) "Insider" includes:

(a) if the debtor is an individual:

(i) a relative of the debtor or of a general partner of the debtor;

(ii) a partnership in which the debtor is a general partner;

(iii) a general partner in a partnership described in subsection (7)(a)(ii); or

(iv) a corporation of which the debtor is a director, officer, or person in control;

(b) if the debtor is a corporation:

(i) a director of the debtor;

(ii) an officer of the debtor;

(iii) a person in control of the debtor;

(iv) a partnership in which the debtor is a general partner;

(v) a general partner in a partnership described in subsection (7)(b)(iv); or

(vi) a relative of a general partner, director, officer, or person in control of the debtor;

(c) if the debtor is a partnership:

(i) a general partner in the debtor;

(ii) a relative of a general partner in, a general partner of, or a person in control of the debtor;

(iii) another partnership in which the debtor is a general partner;

(iv) a general partner in a partnership described in subsection (7)(c)(iii); or

(v) a person in control of the debtor;

(d) an affiliate or an insider of an affiliate as if the affiliate were the debtor; and

(e) a managing agent of the debtor.

(8) "Lien" means a charge against or an interest in property to secure payment of a debt or performance of an obligation and includes a security interest created by agreement, a judicial lien obtained by legal or equitable process or proceedings, a common-law lien, or a statutory lien.

(9) "Person" means an individual, partnership, corporation, association, organization, government or governmental subdivision or agency, business trust, estate, trust, or any other legal or commercial entity.

(10) "Property" means anything that may be the subject of ownership.

(11) "Relative" means:

(a) an individual related by consanguinity within the third degree as determined by the common law;

(b) a spouse or an individual related to a spouse within the third degree as so determined; or

(c) an individual in an adoptive relationship within the third degree.

(12) "Transfer" means every mode, direct or indirect, absolute or conditional, voluntary or involuntary, of disposing of or parting with an asset or an interest in an asset and includes payment of money, release, lease, and creation of a lien or other encumbrance.

(13) "Valid lien" means a lien that is effective against the holder of a judicial lien subsequently obtained by legal or equitable process or proceedings.

History: En. Sec. 2, Ch. 324, L. 1991.

31-2-329. Insolvency. (1) A debtor is insolvent if the sum of the debtor's debts is greater than all of the debtor's property at a fair valuation and the debtor is generally not paying the debtor's debts as they become due.

(2) Property under this section does not include property that has been transferred, concealed, or removed with intent to hinder, delay, or defraud creditors or that has been transferred in a manner making the transfer voidable under this part.

History: En. Sec. 3, Ch. 324, L. 1991; amd. Sec. 1000, Ch. 56, L. 2009.

31-2-330. Value. (1) Value is given for a transfer or an obligation if, in exchange for the transfer or obligation, property is transferred or an antecedent debt is secured or satisfied, but value does not include an unperformed promise made other than in the ordinary course of the promisor's business to furnish support to the debtor or another person.

(2) A transfer is made for present value if the exchange between the debtor and the transferee is intended by them to be contemporaneous and is in fact substantially contemporaneous.

History: En. Sec. 4, Ch. 324, L. 1991.

31-2-331 and 31-2-332 reserved.

31-2-333. Transfers fraudulent as to present and future creditors. (1) A transfer made or obligation incurred by a debtor is fraudulent as to a creditor, whether the creditor's claim arose before or after the transfer was made or the obligation was incurred, if the debtor made the transfer or incurred the obligation:

(a) with actual intent to hinder, delay, or defraud any creditor of the debtor; or

(b) without receiving a reasonably equivalent value in exchange for the transfer or obligation and the debtor:

(i) was engaged or was about to engage in a business or a transaction for which the remaining assets of the debtor were unreasonably small in relation to the business or transaction; or

(ii) intended to incur, or believed or reasonably should have believed that the debtor would incur, debts beyond the debtor's ability to pay as they became due.

(2) In determining actual intent under subsection (1)(a), consideration may be given, among other factors, to whether:

(a) the transfer or obligation was to an insider;

(b) the debtor retained possession or control of the property transferred after the transfer;

(c) the transfer or obligation was disclosed or concealed;

(d) before the transfer was made or obligation was incurred, the debtor had been sued or threatened with suit;

(e) the transfer was of substantially all the debtor's assets;

(f) the debtor absconded;

(g) the debtor removed or concealed assets;

(h) the value of the consideration received by the debtor was reasonably equivalent to the value of the asset transferred or the amount of the obligation incurred;

(i) the debtor was insolvent or became insolvent shortly after the transfer was made or the obligation was incurred;

(j) the transfer occurred shortly before or shortly after a substantial debt was incurred; or

(k) the debtor transferred the essential assets of the business to a lienor who transferred the assets to an insider of the debtor.

History: **En. Sec. 5, Ch. 324, L. 1991; amd. Sec. 1001, Ch. 56, L. 2009.**

31-2-334. Transfers fraudulent as to present creditors. (1) A transfer made or obligation incurred by a debtor is fraudulent as to a creditor whose claim arose before the transfer was made or the obligation was incurred if the debtor made the transfer or incurred the obligation without receiving a reasonably equivalent value in exchange for the transfer or obligation and the debtor was insolvent at that time or the debtor became insolvent as a result of the transfer or obligation.

(2) A transfer made by a debtor is fraudulent as to a creditor whose claim arose before the transfer was made if the transfer was made to an insider for an antecedent debt, the debtor was insolvent at that time, and the insider had reasonable cause to believe that the debtor was insolvent.

History: **En. Sec. 6, Ch. 324, L. 1991.**

31-2-335. When transfer made or obligation incurred. For the purposes of this part:

(1) a transfer is made:

(a) with respect to an asset that is real property other than a fixture, but including the interest of a seller or purchaser under a contract for the sale of the asset, when the transfer is so far perfected that a good faith purchaser of the asset from the debtor against whom applicable law permits the transfer to be perfected cannot acquire an interest in the asset that is superior to the interest of the transferee; and

(b) with respect to an asset that is not real property or that is a fixture, when the transfer is so far perfected that a creditor on a simple contract cannot acquire a judicial lien otherwise than under this part that is superior to the interest of the transferee;

(2) if applicable law permits the transfer to be perfected as provided in subsection (1) and the transfer is not perfected before the commencement of an action for relief under this part, the transfer is considered made immediately before the commencement of the action;

(3) if applicable law does not permit the transfer to be perfected as provided in subsection (1), the transfer is considered made when it becomes effective between the debtor and the transferee;

(4) a transfer is not made until the debtor has acquired rights in the asset transferred;

(5) an obligation is incurred:

(a) if oral, when it becomes effective between the parties; or

(b) if evidenced in writing, when the writing executed by the obligor is delivered to or for the benefit of the obligee.

History: En. Sec. 7, Ch. 324, L. 1991.

31-2-336 through 31-2-338 reserved.

31-2-339. Remedies of creditors. (1) In an action for relief against a transfer or obligation under this part, a creditor, subject to the limitations in 31-2-340, may obtain:

(a) avoidance of the transfer or obligation to the extent necessary to satisfy the creditor's claim;

(b) an attachment or other provisional remedy against the asset transferred or other property of the transferee in accordance with the procedure prescribed by Title 27, chapter 18; or

(c) subject to applicable principles of equity and in accordance with applicable rules of civil procedure:

(i) an injunction against further disposition by the debtor or a transferee, or both, of the asset transferred or of other property;

(ii) appointment of a receiver to take charge of the asset transferred or of other property of the transferee; or

(iii) any other relief the circumstances may require.

(2) If a creditor has obtained a judgment on a claim against the debtor, the creditor, if the court so orders, may levy execution on the asset transferred or its proceeds.

History: En. Sec. 8, Ch. 324, L. 1991.

31-2-340. Defenses, liability, and protection of transferee. (1) A transfer or obligation is not voidable under 31-2-333(1)(a) against a person who took in good faith and for a reasonably equivalent value or against any subsequent transferee or obligee.

(2) Except as otherwise provided in this section, to the extent a transfer is voidable in an action by a creditor under 31-2-339(1)(a), the creditor may recover judgment for the value of the asset transferred, as adjusted under subsection (3), or the amount necessary to satisfy the creditor's claim, whichever is less. The judgment may be entered against:

(a) the first transferee of the asset or the person for whose benefit the transfer was made; or

(b) any subsequent transferee other than a good faith transferee who took for value or from any subsequent transferee.

(3) If the judgment under subsection (2) is based upon the value of the asset transferred, the judgment must be for an amount equal to the value of the asset at the time of the transfer, subject to adjustment as the equities may require.

(4) Notwithstanding voidability of a transfer or an obligation under this part, a good faith transferee or obligee is entitled, to the extent of the value given the debtor for the transfer or obligation, to:

(a) a lien on or a right to retain any interest in the asset transferred;

(b) enforcement of any obligation incurred; or

(c) a reduction in the amount of the liability on the judgment.

(5) A transfer is not voidable under 31-2-333(1)(b) or 31-2-334 if the transfer results from:

(a) termination of a lease upon default by the debtor when the termination is pursuant to the lease and applicable law; or

(b) enforcement of a security interest in compliance with Title 30, chapter 9A.

(6) A transfer is not voidable under 31-2-334(2):

(a) to the extent the insider gave new value to or for the benefit of the debtor after the transfer was made, unless the new value was secured by a valid lien;

(b) if made in the ordinary course of business or financial affairs of the debtor and the insider; or

(c) if made pursuant to a good faith effort to rehabilitate the debtor and the transfer secured present value given for that purpose as well as an antecedent debt of the debtor.

History: **En. Sec. 9, Ch. 324, L. 1991.**

31-2-341. Termination of cause of action. A cause of action with respect to a fraudulent transfer or obligation under this part is terminated unless an action is brought under:

(1) 31-2-333(1)(a) within 4 years after the transfer was made or the obligation was incurred or, if later, within 2 years after the transfer or obligation was or could reasonably have been discovered by the claimant;

(2) 31-2-333(1)(b) or 31-2-334(1) within 4 years after the transfer was made or the obligation was incurred; or

(3) 31-2-334(2) within 2 years after the transfer was made or the obligation was incurred.

History: **En. Sec. 10, Ch. 324, L. 1991; amd. Sec. 1, Ch. 440, L. 2005.**

31-2-342. Supplementary provisions. Unless displaced by the provisions of this part, the principles of law and equity, including the law merchant and the law relating to principal and agent, estoppel, laches, fraud, misrepresentation, duress, coercion, mistake, insolvency, or other validating or invalidating cause, supplement its provisions.

History: **En. Sec. 11, Ch. 324, L. 1991.**

CHAPTER 3
RELATED CREDIT PRACTICES

Part 1 — Consumer Reporting Agencies

31-3-101. Purpose.
31-3-102. Definitions and rules of construction.
31-3-103. Credit rating — property right.
31-3-104 through 31-3-110 reserved.
31-3-111. Permissible purposes of reports.
31-3-112. Obsolete information.
31-3-113. Disclosure of investigative consumer reports.
31-3-114. Compliance procedures.
31-3-115. Adverse information.
31-3-116 through 31-3-120 reserved.
31-3-121. Disclosures to governmental agencies.
31-3-122. Disclosures to consumers.
31-3-123. Conditions of disclosure to consumer.
31-3-124. Procedure in case of disputed accuracy.
31-3-125. Fees for disclosures to consumers.
31-3-126. Public record information for employment purposes.
31-3-127. Repealed.
31-3-128 through 31-3-130 reserved.
31-3-131. Requirements on users of consumer reports.
31-3-132. Block of information on credit report.
31-3-133 through 31-3-140 reserved.
31-3-141. Actions available to consumer.
31-3-142. Civil liability for willful noncompliance.
31-3-143. Civil liability for negligent noncompliance.
31-3-144 through 31-3-150 reserved.
31-3-151. Jurisdiction — venue.
31-3-152. Rules.
31-3-153. Violation.

Part 2 — Debt Adjusting (Repealed)

Part 1
Consumer Reporting Agencies

Part Cross-References

Unfair trade practices and consumer protection, Title 30, ch. 14.

31-3-101. Purpose. It is the purpose of this part to require that consumer reporting agencies adopt reasonable procedures for meeting the needs of commerce for consumer credit, personnel, insurance, and other information in a manner which is fair and equitable to the consumer, with regard to the confidentiality, accuracy, relevancy, and proper utilization of such information in accordance with the requirements of this part. A further purpose of this part is to guard an individual's right to privacy guaranteed in Article II, section 10, of the Montana constitution.

History: En. 18-501 by Sec. 1, Ch. 547, L. 1975; R.C.M. 1947, 18-501.

31-3-102. Definitions and rules of construction. (1) Definitions and rules of construction set forth in this section are applicable for the purposes of this part.

(2) The term "consumer" means an individual.

(3) (a) The term "consumer report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer's eligibility for:

(i) credit or insurance to be used primarily for personal, family, or household purposes;

(ii) employment purposes; or

(iii) other purposes authorized under 31-3-111.

(b) The term does not include:

(i) any report containing information solely as to transactions or experiences between the consumer and the person making the report;

(ii) any authorization or approval of a specific extension of credit, directly or indirectly, by the issuer of a credit card or similar device; or

(iii) any report in which a person who has been requested by a third party to make a specific extension of credit, directly or indirectly, to a consumer conveys the consumer's decision with respect to the request if the third party advises the consumer of the name and address of the person to whom the request was made and that person makes the disclosures to the consumer required under 31-3-131.

(4) The term "consumer reporting agency" means any person that, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(5) The term "employment purposes", when used in connection with a consumer report, means a report used for the purpose of evaluating a consumer for employment, promotion, reassignment, or retention as an employee.

(6) The term "file", when used in connection with information on any consumer, means all of the information on that consumer recorded and retained by a consumer reporting agency regardless of how the information is stored.

(7) The term "investigative consumer report" means a consumer report or portion of a consumer report in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with neighbors, friends, or associates of the consumer reported on or with others with whom the consumer is acquainted or who may have knowledge concerning any items of information. However, the information may not include specific factual information on a consumer's credit record obtained directly from a creditor of the consumer or from a consumer reporting agency when the information was obtained directly from a creditor of the consumer or from the consumer.

(8) The term "medical information" means information or records obtained, with the consent of the individual to whom it relates, from licensed physicians or medical practitioners, hospitals, clinics, or other medical or medically related facilities.

(9) The term "person" means any individual, partnership, corporation, trust, estate, cooperative, association, government or governmental subdivision or agency, or other entity.

History: En. 18-502 by Sec. 2, Ch. 547, L. 1975; R.C.M. 1947, 18-502; amd. Sec. 1002, Ch. 56, L. 2009.

31-3-103. Credit rating — property right. A credit rating is a property right with full constitutional protection.

History: En. 18-503 by Sec. 3, Ch. 547, L. 1975; R.C.M. 1947, 18-503.

Cross-References

Due process of law, Art. II, sec. 17, Mont. Const.

31-3-104 through 31-3-110 reserved.

31-3-111. Permissible purposes of reports. A consumer reporting agency may furnish a consumer report under the following circumstances and no other:

(1) in response to the order of a court having jurisdiction to issue such an order;

(2) in accordance with the written instructions of the consumer to whom it relates;

(3) to a person which it has reason to believe:

(a) intends to use the information in connection with a credit transaction involving the consumer on whom the information is to be furnished and involving the extension of credit to, or review or collection of an account of, the consumer;

(b) intends to use the information for employment purposes;

(c) intends to use the information in connection with the underwriting of insurance involving the consumer;

(d) intends to use the information in connection with a determination of the consumer's eligibility for a license or other benefit granted by a governmental instrumentality required by law to consider an applicant's financial responsibility or status; or

(e) otherwise has a legitimate business need for the information in connection with a business transaction involving the consumer.

History: En. 18-504 by Sec. 4, Ch. 547, L. 1975; R.C.M. 1947, 18-504.

Cross-References

Consumer protection — unlawful practices, 30-14-103.
Retail installment sales, Title 31, ch. 1, part 2.
Consumer loan businesses — Montana Consumer Loan Act, Title 32, ch. 5.
Insurance, Title 33.
Employment relationship, Title 39, ch. 2.

31-3-112. Obsolete information. No consumer reporting agency may make any consumer report containing any of the following items of information:

(1) bankruptcies which, from date of adjudication of the most recent bankruptcy, antedate the report by more than 14 years;

(2) suits and judgments which, from date of entry, antedate the report by more than 7 years or until the governing statute of limitations has expired, whichever is the longer period;

(3) paid tax liens which, from date of payment, antedate the report by more than 7 years;

(4) accounts placed for collection or charged to profit and loss which antedate the report by more than 7 years;

(5) records of arrest, indictment, or conviction of crime which, from date of disposition, release, or parole, antedate the report by more than 7 years;

(6) any other adverse item of information which antedates the report by more than 7 years.

History: En. 18-505 by Sec. 5, Ch. 547, L. 1975; R.C.M. 1947, 18-505.

Cross-References

Criminal justice policy — rights of convicted, Art. II, sec. 28, Mont. Const.
Tax liens and limitations, Title 15, ch. 16, part 4.

31-3-113. Disclosure of investigative consumer reports. (1) A person may not procure or cause to be prepared or distribute an investigative consumer report on any consumer unless:

(a) it is clearly and accurately disclosed to the consumer that an investigative consumer report, including information as to the consumer's character, general reputation, personal characteristics, and mode of living, whichever are applicable, may be made and the disclosure is made in a writing mailed or otherwise delivered to the consumer not later than 3 days after the date on which the report was first requested and includes a statement informing the consumer of the right to request the additional disclosures provided for under subsection (2); or

(b) the report is to be used for employment purposes for which the consumer applied.

(2) Any person who procures or causes to be prepared an investigative consumer report on any consumer shall, upon written request made by the consumer within a reasonable period of time after the receipt by the person of the disclosure required by subsection (1)(a), make a complete and accurate disclosure of the nature, scope, and substance of the investigation requested. This disclosure must be made in a writing and must be mailed or otherwise delivered to the consumer not later than 5 days after the date on which the request for the disclosure was received from the consumer or the report was first requested, whichever is later.

(3) A person may not be held liable for any violation of subsection (1) or (2) if the person shows by a preponderance of the evidence that at the time of the violation the person maintained reasonable procedures to ensure compliance with subsection (1) or (2).

History: **En. 18-506 by Sec. 6, Ch. 547, L. 1975; R.C.M. 1947, 18-506; amd. Sec. 1003, Ch. 56, L. 2009.**

Cross-References

Right of privacy, Art. II, sec. 10, Mont. Const.

Employment relationship, Title 39, ch. 2.

31-3-114. Compliance procedures. (1) Every consumer reporting agency shall maintain reasonable procedures designed to avoid violations of 31-3-112 and 31-3-113 and to limit the furnishing of consumer reports to the purposes listed under 31-3-111. These procedures must require that prospective users of the information identify themselves, certify the purposes for which the information is sought, and certify that the information will be used for no other purpose. Every consumer reporting agency shall make a reasonable effort to verify the identity of a new prospective user and the uses certified by the prospective user prior to furnishing the user a consumer report. A consumer reporting agency may not furnish a consumer report to any person if it has reasonable grounds for believing that the consumer report will not be used for a purpose listed in 31-3-111.

(2) Whenever a consumer reporting agency prepares a consumer report, it shall follow reasonable procedures to assure maximum possible accuracy of the information concerning the individual about whom the report relates, and it shall maintain a record of all persons using the information and the source of each piece of information.

(3) When gathering information, a consumer reporting agency shall notify any person who furnishes information that the person is liable to suit if the information is false or furnished with malice or willful intent to injure the consumer.

History: **En. 18-507 by Sec. 7, Ch. 547, L. 1975; R.C.M. 1947, 18-507; amd. Sec. 1004, Ch. 56, L. 2009.**

Cross-References

Libel and slander, Title 27, ch. 1, part 8.

Montana Unfair Trade Practices and Consumer Protection Act of 1973, Title 30, ch. 14, part 1.

31-3-115. Adverse information. (1) Whenever a consumer reporting agency prepares an investigative consumer report, adverse information in the consumer report, other than information that is a matter of public record, may not be included in a subsequent consumer report unless the adverse information has been verified in the process of making the subsequent consumer report.

(2) A consumer reporting agency shall block the reporting of any information in the file of a consumer that the consumer identifies as information that resulted from an alleged identity theft, pursuant to 15 U.S.C. 1681c-2.

History: **En. 18-508 by Sec. 8, Ch. 547, L. 1975; R.C.M. 1947, 18-508; amd. Sec. 1, Ch. 518, L. 2005.**

31-3-116 through 31-3-120 reserved.

31-3-121. Disclosures to governmental agencies. Notwithstanding the provisions of 31-3-111, a consumer reporting agency may furnish identifying information respecting any consumer, limited to the consumer's name, address, former addresses, places of employment, or former places of employment, to a governmental agency.

History: **En. 18-509 by Sec. 9, Ch. 547, L. 1975; R.C.M. 1947, 18-509; amd. Sec. 1005, Ch. 56, L. 2009.**

31-3-122. Disclosures to consumers. (1) Every consumer reporting agency shall, upon request and proper identification of any consumer, clearly and accurately disclose to the consumer:

(a) the nature and substance of all information (except medical information) in its files on the consumer at the time of the request; and

(b) the sources of the information.

(2) The requirements of subsection (1) respecting the disclosure of sources of information and the recipients of consumer reports furnished prior to July 1, 1975, do not apply to existing consumer reporting agencies except to the extent that the matter involved is contained in the files of the consumer reporting agency on that date.

History: **En. 18-510 by Sec. 10, Ch. 547, L. 1975; amd. Sec. 3, Ch. 185, L. 1977; R.C.M. 1947, 18-510.**

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.

Montana Unfair Trade Practices and Consumer Protection Act of 1973, Title 30, ch. 14, part 1.

31-3-123. Conditions of disclosure to consumer. (1) A consumer reporting agency shall make the disclosures required under 31-3-122 during normal business hours and on reasonable notice.

(2) The disclosures required under 31-3-122 must be made to the consumer:

(a) in person if the consumer appears in person and furnishes proper identification; or

(b) by telephone if the consumer has made a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call is prepaid by or charged directly to the consumer.

(3) Any consumer reporting agency shall provide trained personnel to explain to the consumer any information furnished to the consumer pursuant to 31-3-122.

(4) The consumer must be permitted to be accompanied by one other person of the consumer's choosing, who shall furnish reasonable identification. A consumer reporting agency may require the consumer to furnish a written statement granting permission to the consumer reporting agency to discuss the consumer's file in the other person's presence.

History: **En. 18-511 by Sec. 11, Ch. 547, L. 1975; R.C.M. 1947, 18-511; amd. Sec. 1006, Ch. 56, L. 2009.**

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.

31-3-124. Procedure in case of disputed accuracy. (1) If the completeness or accuracy of any item of information contained in this file is disputed by a consumer and the dispute is directly conveyed to the consumer reporting agency by the consumer, the consumer reporting agency shall within a reasonable period of time reinvestigate and record the current status of that information unless it has reasonable grounds to believe that the dispute by the consumer is frivolous or irrelevant. If after such reinvestigation such information is found to be inaccurate or can no longer be verified, the consumer reporting agency shall promptly delete the information and notify all users, of whom the consumer reporting agency has records, of the information's deletion. The users shall also delete the information.

(2) If the reinvestigation does not resolve the dispute, the consumer may file a brief statement setting forth the nature of the dispute.

(3) Whenever a statement of a dispute is filed, unless there are reasonable grounds to believe that it is frivolous or irrelevant, the consumer reporting agency shall, in any subsequent consumer report containing the information in question, clearly note that it is disputed by the consumer and provide either the consumer's statement or a clear and accurate codification or summary thereof. The consumer reporting agency shall notify the consumer of all users, of whom it has records, who have the disputed information.

History: **En. 18-512 by Sec. 12, Ch. 547, L. 1975; R.C.M. 1947, 18-512.**

31-3-125. Fees for disclosures to consumers. A consumer reporting agency shall make all disclosures pursuant to 31-3-122 and 31-3-124 to the consumer, with appropriate fees to be established by the department of administration in accordance with the Montana Administrative Procedure Act.

History: **En. 18-513 by Sec. 13, Ch. 547, L. 1975; R.C.M. 1947, 18-513; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 72, Ch. 483, L. 2001.**

Cross-References

Montana Administrative Procedure Act — adoption and publication of rules, Title 2, ch. 4, part 3.

31-3-126. Public record information for employment purposes. A consumer reporting agency which furnishes a consumer report for employment purposes and which for that purpose compiles and reports items of information on consumers which are matters of public record and are likely to have an adverse effect upon a consumer's ability to obtain employment shall:

(1) at the time such public record information is reported to the user of such consumer report, notify the consumer of the fact that public record information is being reported by the consumer reporting agency, together with the name and address of the person to whom such information is being reported; or

(2) maintain strict procedures designed to insure that whenever public record information which is likely to have an adverse effect on a consumer's ability to obtain employment is reported it is complete and up-to-date. For purposes of this paragraph, items of public record relating to arrests, indictments, convictions, suits, tax liens, and outstanding judgments shall be considered up-to-date if the current public record status of the item at the time of the report is reported.

History: En. 18-514 by Sec. 14, Ch. 547, L. 1975; R.C.M. 1947, 18-514.

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.
Public records management, Title 2, ch. 6, parts 10 and 11.

31-3-127. Repealed. Sec. 10, Ch. 418, L. 1989.

History: En. Sec. 1, Ch. 543, L. 1985.

31-3-128 through 31-3-130 reserved.

31-3-131. Requirements on users of consumer reports. (1) Whenever credit or insurance for personal, family, or household purposes or employment involving a consumer is denied or the charge for the credit or insurance is increased either wholly or partly because of information contained in a consumer report from a consumer reporting agency, the user of the consumer report shall advise the consumer against whom the adverse action has been taken and supply the name and address of the consumer reporting agency making the report.

(2) Whenever credit for personal, family, or household purposes involving a consumer is denied or the charge for the credit is increased either wholly or partly because of information obtained from a person other than a consumer reporting agency bearing upon the consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living, the user of the information shall, within a reasonable period of time, upon the consumer's written request for the reasons for the adverse action received within 60 days after the consumer learned of the adverse action, disclose the nature of the information to the consumer. The user of the information shall clearly and accurately disclose to the consumer the right to make the written request at the time the adverse action is communicated to the consumer.

(3) A person may not be held liable for any violation of this section if the person shows by a preponderance of the evidence that at the time of the alleged violation the person maintained reasonable procedures to ensure compliance with the provisions of subsections (1) and (2).

History: En. 18-515 by Sec. 15, Ch. 547, L. 1975; amd. Sec. 4, Ch. 185, L. 1977; R.C.M. 1947, 18-515; amd. Sec. 1007, Ch. 56, L. 2009.

Cross-References

Libel and slander, Title 27, ch. 1, part 8.
Consumer protection — unlawful practices, 30-14-103.

31-3-132. Block of information on credit report. (1) Within 30 days after a consumer reporting agency receives from a consumer a complaint of identity theft and documentation as provided in subsection (2), the consumer reporting agency shall permanently block any information that the consumer identifies from the consumer's report that resulted from identity theft as defined in 45-6-332.

(2) To request a block of information on a consumer report, a consumer shall provide a consumer reporting agency with:

(a) a copy of a police report or an identity theft passport as provided in 46-24-220;

(b) the specific description of information that is to be blocked because it was a result of a violation of 45-6-332.

(3) A consumer reporting agency shall notify the person furnishing the information that a police report has been filed and that a block has been requested and shall notify the person of the effective date of the block.

(4) A consumer reporting agency may decline to block information or may rescind any block of information if, in the exercise of good faith and reasonable judgment, the consumer reporting agency believes that:

(a) the information was blocked because of a misrepresentation of fact by the consumer in requesting the block under this section;

(b) the consumer agrees that the blocked information or portions of the blocked information were blocked in error; or

(c) the consumer knowingly obtained possession of goods, services, or money as a result of the transaction for which information was blocked or the consumer should have known that possession of goods, services, or money occurred because of the transaction for which information was blocked.

(5) If a consumer reporting agency declines to block information or rescinds a blocking of information under this section, the consumer reporting agency shall notify the consumer promptly in the same manner as required in 15 U.S.C. 1681i. The prior presence of the blocked information in the consumer reporting agency's file on the consumer is not evidence of whether the consumer knew or should have known that the consumer obtained possession of any goods, services, or money.

(6) In order to facilitate a consumer's right to block information as provided in subsection (1), a law enforcement agency shall provide to the consumer at the consumer's request a copy of a police report filed by the consumer that indicates that the consumer is a victim under 45-6-332.

History: En. Sec. 3, Ch. 195, L. 2007.

31-3-133 through 31-3-140 reserved.

31-3-141. Actions available to consumer. (1) A consumer may bring action in the nature of defamation, invasion of privacy, or negligence with respect to the reporting of information against any person who fails to comply with this part.

(2) A person who fails to delete information or incorporate into a report a consumer's statement of dispute because the person judges the dispute to be frivolous or irrelevant is liable to suit.

(3) A person, other than the department of public health and human services under 40-5-261, who furnishes information to a consumer reporting agency that is false or a person who furnishes the information with malice or willful intent to injure the concerned consumer is liable to suit.

(4) A consumer who disputes the result of a reinvestigation conducted under 31-3-124 of the accuracy of information provided by the department of public health and human services may petition for an administrative hearing pursuant to 40-5-261.

History: En. 18-516 by Sec. 16, Ch. 547, L. 1975; R.C.M. 1947, 18-516; amd. Sec. 1, Ch. 418, L. 1989; amd. Sec. 35, Ch. 16, L. 1991; amd. Sec. 82, Ch. 546, L. 1995.

Cross-References

Right of privacy, Art. II, sec. 10, Mont. Const.
Liability for negligence as well as willful acts, 27-1-701.
Defamation — how effected, 27-1-801.

31-3-142. Civil liability for willful noncompliance. Any consumer reporting agency or user of information which willfully fails to comply with any requirement imposed under this part with respect to any consumer is liable to that consumer in an amount equal to the sum of:

(1) any actual damages sustained by the consumer as a result of the failure;

(2) such amounts of punitive damages as the court may allow; and

(3) in the case of any successful action to enforce any liability under this section, the costs of the action together with reasonable attorneys' fees as determined by the court.

History: En. 18-517 by Sec. 17, Ch. 547, L. 1975; R.C.M. 1947, 18-517.

Cross-References

Allowable costs, Title 25, ch. 10, part 2.
Attorney fees, Title 25, ch. 10, part 3.
Damages, Title 27, ch. 1, part 2.
When punitive damages allowed, 27-1-221.
Measure of damages, Title 27, ch. 1, part 3.

31-3-143. Civil liability for negligent noncompliance. Any consumer reporting agency or user of information which is negligent in failing to comply with any requirement imposed under this part with respect to any consumer is liable to that consumer in an amount equal to the sum of:

(1) any actual damages sustained by the consumer as a result of the failure;

(2) in the case of any successful action to enforce any liability under this section, the costs of the action together with reasonable attorneys' fees as determined by the court.

History: En. 18-518 by Sec. 18, Ch. 547, L. 1975; R.C.M. 1947, 18-518.

Cross-References

Allowable costs, Title 25, ch. 10, part 2.
Attorney fees, Title 25, ch. 10, part 3.
Damages, Title 27, ch. 1, part 2.
Measure of damages, Title 27, ch. 1, part 3.
Liability for negligence as well as willful acts, 27-1-701.

31-3-144 through 31-3-150 reserved.

31-3-151. Jurisdiction — venue. A consumer may bring suit in any district court in Montana, except that disputes concerning information provided under 40-5-261 are subject to administrative and judicial review as provided in 40-5-261.

History: En. 18-519 by Sec. 19, Ch. 547, L. 1975; R.C.M. 1947, 18-519; amd. Sec. 2, Ch. 418, L. 1989.

Cross-References

District Court jurisdiction, Title 3, ch. 5, part 3.
Venue, Title 25, ch. 2.

31-3-152. Rules. The department of administration shall enforce this part and adopt rules necessary to carry out the intent of this part.

History: En. 18-520 by Sec. 20, Ch. 547, L. 1975; R.C.M. 1947, 18-520; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 2, Ch. 543, L. 1985; amd. Sec. 3, Ch. 418, L. 1989; amd. Sec. 73, Ch. 483, L. 2001.

Cross-References

Montana Administrative Procedure Act — adoption and publication of rules, Title 2, ch. 4, part 3.

31-3-153. Violation. For the purposes of this part, a violation of this law would be in violation of Title 30, chapter 14, part 1.

History: En. 18-521 by Sec. 21, Ch. 547, L. 1975; R.C.M. 1947, 18-521.

Cross-References

Damages, 30-14-133.
Penalties, 30-14-142.

Part 2
Debt Adjusting
(Repealed)

31-3-201. Repealed. Sec. 10, Ch. 272, L. 2005.

History: En. Sec. 1, Ch. 300, L. 1969; R.C.M. 1947, 18-401.

31-3-202. Repealed. Sec. 10, Ch. 272, L. 2005.

History: En. Sec. 2, Ch. 300, L. 1969; R.C.M. 1947, 18-402.

31-3-203. Repealed. Sec. 10, Ch. 272, L. 2005.

History: En. Sec. 3, Ch. 300, L. 1969; amd. Sec. 2, Ch. 185, L. 1977; R.C.M. 1947, 18-403; amd. Sec. 1, Ch. 295, L. 1989; amd. Sec. 74, Ch. 483, L. 2001.

CHAPTER 4
LITIGATION FINANCING

Part 1 — Litigation Financing Transparency and Consumer Protection Act

31-4-101. Short title.
31-4-102. Definitions.
31-4-103. Registration.
31-4-104. Litigation financing protections.
31-4-105 and 31-4-106 reserved.
31-4-107. Litigation financing contract — disclosures.
31-4-108. Disclosure and discovery of litigation financing contracts.
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31-4-112. Class actions.
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31-4-118. Exemptions.
31-4-119. Act violation — unenforceable contract.
31-4-120. Joint and several liability for costs.
31-4-121 through 31-4-124 reserved.
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Part 2 — Foreign Investment in Litigation Financing Act

31-4-201. Short title.
31-4-202. Definitions.
31-4-203. Prohibition on litigation funding by foreign adversaries or foreign persons of concern.
31-4-204. Restriction on disclosure of proprietary information.
31-4-205. Limitations on foreign litigation funding.
31-4-206. Registration and transparency of foreign persons.

Part 1
Litigation Financing Transparency and Consumer Protection Act

31-4-101. Short title. This part may be cited as the "Litigation Financing Transparency and Consumer Protection Act".

History: En. Sec. 1, Ch. 360, L. 2023.

31-4-102. Definitions. For the purposes of this part, the following definitions apply:

(1) "Consumer" means any person who is or may become a plaintiff, claimant, or complainant in conjunction with or in pursuit of a legal claim.

(2) "Entity" means any domestic or foreign corporation, partnership, limited partnership, limited liability company, trust, fund, plan, or any other business, enterprise, association, or organization of any kind or nature.

(3) "Legal claim" means a civil action, administrative proceeding, claim, or cause of action to recover damages or any form of monetary or injunctive relief in this state.

(4) "Legal representative" means an attorney or group of attorneys or law firm or group of law firms engaged to represent a consumer in conjunction with or in pursuit of a legal claim.

(5) (a) "Litigation financer" means any person or group of persons engaged in, or formed, created, or established for the purpose of engaging in, the business of litigation financing or any other business or economic activity in which a person or group of persons receive consideration of any kind in exchange for providing litigation financing.

(b) The term does not include:

(i) a party to the legal claim;

(ii) a legal representative engaged directly, or indirectly through another legal representative, to represent a party in conjunction with or in pursuit of the legal claim; or

(iii) an entity or insurer with a preexisting contractual obligation to indemnify or defend a party to a legal claim.

(6) "Litigation financing" means:

(a) the financing, funding, advancing, or loaning of money to a legal representative or to any person who has or may pursue or assert a legal claim or who is or may become a plaintiff in conjunction with or in pursuit of a legal claim if:

(i) repayment of all or a portion of the amount financed, funded, advanced, or loaned is contingent in any respect on the outcome of a legal claim or group of legal claims;

(ii) repayment is required only if the person prevails in conjunction with or in pursuit of a legal claim; or

(iii) the money or funds for the repayment of any amount of the financing, funding, advance, or loan is derived or sourced, directly or indirectly, from the proceeds of or other consideration realized from a judgment, award, settlement, verdict, or other form of monetary relief the person or legal representative may receive or recover in conjunction with or in pursuit of a legal claim or group of legal claims; or

(b) any agreement or arrangement involving the financing, funding, advancing, or loaning of money to a legal representative if the repayment of all or a portion of the amount financed, funded, advanced, or loaned is contingent on the outcome of any single legal claim or group of legal claims in which the legal representative represents one or more consumers.

(7) (a) "Litigation financing contract" means a written contract in which a person agrees to provide litigation financing to any person in consideration for:

(i) the payment of interest, fees, or other consideration to the person providing the litigation financing; or

(ii) granting or assigning to the person providing the litigation financing a right to receive payment from the value of any proceeds or other consideration realized from any judgment, award, settlement, verdict, or other form of monetary relief any consumer, legal representative, or other person may receive or recover in relation to the legal claim.

(b) The term includes an agreement related to a litigation financing contract.

(c) The term does not include any agreement, contract, or engagement of a legal representative to render legal services to a consumer on a contingency fee basis, including the advancement of legal costs by the legal representative, in which the services or costs are provided to or on behalf of a consumer by the legal representative representing the consumer in the legal claim.

(8) "Person" means an individual or an entity.

(9) "Proprietary information" means any documents, records, or information received by a party in conjunction with or in pursuit of a legal claim that has economic or commercial value in any person's business and is:

(a) designated as proprietary information by a party to the legal claim; or

(b) subject to a court order to protect, seal, or otherwise restrict the disclosure or sharing of the documents, records, or information.

(10) "Regulated lender" has the same meaning as in 31-1-111.

(11) "Secretary" means the secretary of state provided for in Title 2, chapter 15, part 4.

History: En. Sec. 2, Ch. 360, L. 2023; amd. Sec. 1, Ch. 413, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 1, Ch. 413, L. 2025. Amendment effective May 5, 2025.

Applicability: Section 15, Ch. 413, L. 2025, provided: "[This act] applies to litigation financing contracts entered into on or after [the effective date of this act]." Effective May 5, 2025.

31-4-103. Registration. (1) A person may not engage in litigation financing in this state unless the person is registered with the secretary of state as a litigation financer pursuant to this part.

(2) If the person registering as a litigation financer is an entity:

(a) the entity must be active and in good standing as reflected in the office of the secretary of state; and

(b) the entity's articles of incorporation, charter, articles of organization, certificate of limited partnership, or other organizational or governing document must contain a statement that the entity has the power to engage in the business of litigation financing and is designated as a litigation financer pursuant to this part.

(3) To register as a litigation financer, a person shall file a registration statement with the secretary of state setting forth the following information:

(a) the legal name of the litigation financer;

(b) the physical street address and mailing address of the litigation financer;

(c) a telephone number or e-mail address through which the litigation financer may be contacted;

(d) the physical street address and mailing address of the licensed financer's registered office and the name of the registered agent at the registered office who is authorized to accept service of process on behalf of the licensed financer; and

(e) any other information the secretary of state considers necessary.

(4) If the person seeking to register as a litigation financer is an entity, the following information must be set forth in the registration statement with respect to each person that, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 5% or more of the voting securities of the litigation financer:

(a) the legal name, physical street address, and mailing address of each person;

(b) if the person is an individual:

(i) the individual's occupation;

(ii) any offices and positions held with the litigation financer during the past 5 years; and

(iii) any conviction of a crime other than misdemeanor traffic violations during the past 10 years;

(c) if the person is an entity:

(i) the nature of the entity's business operations, if any, during the past 5 years or a description of the business intended to be done by the entity and the entity's subsidiaries, if any; and

(ii) a list of all individuals who are or who have been selected to become directors or officers of the entity and each subsidiary of the entity. The list must include for each individual the information required by subsection (2).

(5) A litigation financer subject to registration under this part shall file an amended registration within 30 days whenever the information contained in the most recently filed registration changes or becomes inaccurate or incomplete in any respect.

(6) The secretary of state is authorized to prescribe the forms and the filing fees the secretary of state considers necessary for the purposes of this part.

(7) All documents and information filed with the secretary of state pursuant to this section are public records.

(8) The secretary of state's duty to file documents under this section is ministerial. The secretary of state's filing or refusing to file a document does not create a presumption that:

(a) the document does or does not conform to the requirements of this chapter; or

(b) the information contained in the document is correct or incorrect.

History: **En. Sec. 3, Ch. 360, L. 2023.**

31-4-104. Litigation financing protections. (1) A litigation financer may not:

(a) pay or offer commissions, referral fees, rebates, or other forms of consideration to any person in exchange for referring a consumer to a litigation financer;

(b) accept any commissions, referral fees, rebates, or other forms of consideration from any person providing any goods or rendering any services to the consumer;

(c) charge a rate of interest that exceeds the rate of interest allowed under 31-1-107;

(d) receive or recover any payment that exceeds 25% of the amount of any judgment, award, settlement, verdict, or other form of monetary relief obtained in the civil action, administrative proceeding, claim, or cause of action that is the subject of the litigation contract;

(e) advertise false or misleading information regarding its products or services;

(f) refer or require any consumer to hire or engage any person providing any goods or rendering any services to the consumer;

(g) fail to promptly deliver a fully completed and signed litigation financing contract to the consumer and the consumer's legal representative;

(h) attempt to secure a remedy or obtain a waiver of any remedy, including but not limited to compensatory, statutory, or punitive damages, that the consumer may or may not be entitled to pursue or recover otherwise;

(i) offer or provide legal advice to the consumer;

(j) assign, including securitizing, a litigation financing contract in whole or in part;

(k) report a consumer to a credit reporting agency if insufficient funds remain to repay the litigation financer in full from the proceeds received from any judgment, award, settlement, verdict, or other form of monetary relief obtained in the civil action, administrative proceeding, claim, or cause of action that is the subject of the litigation financing contract;

(l) make a decision, influence, or direct a decision regarding a legal claim to recover damages including decisions in appointing or changing counsel, choice or use of expert witnesses, litigation strategy, and settlement or other resolution; or

(m) demand, request, receive, or exercise any right to influence, affect, or otherwise make any decision in the handling, conduct, administration, litigation, settlement, or resolution of any civil action, administrative proceeding, claim, or cause of action in which the litigation financer has provided litigation financing. All rights remain solely with the consumer and the consumer's legal representative.

(2) A person who provides any goods or renders any services to the consumer may not have a financial interest in litigation financing and may not receive any commissions, referral fees, rebates, or other forms of consideration from any litigation financer or the litigation financer's employees, owners, or affiliates.

(3) A party, attorney or law firm representing a party, or affiliated attorney or law firm may not disclose or share any information with a litigation financer that is subject to a protective or sealing order from a court.

(4) A party to a legal claim may not disclose to or share with a litigation financer any proprietary information received in the course of or in conjunction with a legal claim.

History: En. Sec. 4, Ch. 360, L. 2023; amd. Sec. 2, Ch. 413, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 2, Ch. 413, L. 2025. Amendment effective May 5, 2025.

Applicability: Section 15, Ch. 413, L. 2025, provided: "[This act] applies to litigation financing contracts entered into on or after [the effective date of this act]." Effective May 5, 2025.

31-4-105 and 31-4-106 reserved.

31-4-107. Litigation financing contract — disclosures. (1) The terms and conditions of a litigation financing contract must be set forth in a fully completed written contract with no terms or conditions omitted. The litigation financing contract must contain all terms and conditions at the time it is signed by any party to the litigation financing contract.

(2) On execution of a litigation financing contract, a litigation financer may not amend the terms or conditions of the litigation financing contract without full disclosure to and the prior written consent of all parties to the litigation financing contract.

(3) A litigation financing contract must set forth the name, physical street address, and mailing address of the litigation financer on page 1 of the litigation financing contract.

(4) A litigation financing contract must contain the following disclosures that constitute material terms and conditions of the litigation financing contract and must be typed in at least 14-point bold font and be placed clearly and conspicuously immediately above the consumer's signature line in the litigation financing contract:

"IMPORTANT DISCLOSURES — PLEASE READ CAREFULLY

1. Right to Cancellation: You may cancel this litigation financing contract without penalty or further obligation within five (5) business days from the date you sign this contract or the date you receive financing from the litigation financer, whichever date is later. You may cancel by sending a notice of cancellation to the litigation financer and returning to the litigation financer any funds received from the litigation financer at the litigation financer's address set forth on page 1 of this contract.

2. The maximum amount the litigation financer may receive or recover from any payment may not exceed twenty-five percent (25%) of the amount of any judgment, award, settlement, verdict, or other form of monetary relief obtained in the civil action, administrative proceeding, claim, or cause of action that is the subject of this litigation contract.

3. The litigation financer agrees that it has no right to, and will not demand, request, receive, or exercise any right to, influence, affect, or otherwise make any decision in the handling, conduct, administration, litigation, settlement, or resolution of your civil action, administrative proceeding, claim, or cause of action. All of these rights remain solely with you and your legal representative.

4. If there is no recovery of any money from your civil action, administrative proceeding, claim, or cause of action, or if there is not enough money to satisfy in full the portion assigned to the litigation financer, you will not owe anything in excess of your recovery.

5. You are entitled to a fully completed contract with no terms or conditions omitted prior to signing. Before signing this contract, you should read the contract completely and consult an attorney."

(5) If the consumer is represented by a legal representative in the civil action, administrative proceeding, claim, or cause of action that is the subject of the litigation financing contract, the legal representative shall acknowledge in the contract that the legal representative and the legal representative's employer and employees have not received or paid a referral fee or any other consideration from or to the litigation financer and have no obligation to do so in the future.

(6) If the consumer's legal representative is a party to a litigation financing contract related to the consumer's civil action, administrative proceeding, claim, or cause of action that is the subject of the litigation financing contract, the legal representative shall disclose and deliver the litigation financing contract to the consumer. Following this disclosure and delivery, the consumer shall sign an acknowledgment that the consumer has read and understands the terms and conditions of the litigation financing contract and the consumer must be provided with a copy of the acknowledgment.

History: **En. Sec. 5, Ch. 360, L. 2023.**

31-4-108. Disclosure and discovery of litigation financing contracts. (1) Except as otherwise stipulated or ordered by a court of competent jurisdiction, a consumer or the consumer's legal representative or a party or a party's legal representative shall, without awaiting a discovery request, disclose and deliver to the following persons the litigation financing contract:

(a) each party to the civil action, administrative proceeding, claim, or cause of action, or to each party's legal representative;

(b) the court, agency, or tribunal in which the civil action, administrative proceeding, claim, or cause of action may be pending; and

(c) any known person, including an insurer, with a preexisting contractual obligation to indemnify or defend a party to the civil action, administrative proceeding, claim, or cause of action.

(2) The disclosure obligation under subsection (1) exists regardless of whether a civil action or an administrative proceeding has commenced.

(3) The disclosure obligation under subsection (1) is a continuing obligation, and within 30 days of entering into a litigation financing contract or amending an existing litigation financing contract, the consumer or the consumer's legal representative or a party or a party's legal representative shall disclose and deliver any new or amended litigation financing contracts.

(4) The existence of the litigation financing contract and all participants or parties to a litigation financing contract are permissible subjects of discovery in any civil action, administrative proceeding, claim, or cause of action to which litigation financing is provided under the litigation financing contract, regardless of whether a civil action or an administrative proceeding has commenced.

History: **En. Sec. 6, Ch. 360, L. 2023; amd. Sec. 3, Ch. 413, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 3, Ch. 413, L. 2025. Amendment effective May 5, 2025.

Applicability: Section 15, Ch. 413, L. 2025, provided: "[This act] applies to litigation financing contracts entered into on or after [the effective date of this act]." Effective May 5, 2025.

31-4-109 through 31-4-111 reserved.

31-4-112. Class actions. This part applies to any civil action filed or certified as a class action in which litigation financing is provided. A litigation financer owes a fiduciary duty to all class members or intended beneficiaries of a certified class and shall act in a manner consistent with the litigation financer's fiduciary duty throughout the civil action. In addition to the disclosure requirements set forth in this part, the legal representative of the putative class shall disclose to all parties, putative class members, and the court any legal, financial, or other relationship between the legal representative and the litigation financer. A class member is entitled to receive from the class counsel a true and correct copy of the litigation financing contract on request.

History: **En. Sec. 8, Ch. 360, L. 2023.**

31-4-113 through 31-4-117 reserved.

31-4-118. Exemptions. This part does not apply to the following:

(1) a nonprofit entity that is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code or a nonprofit entity that provides litigation financing, funding, or money to a legal representative to represent a consumer on a pro bono basis, provided that the nonprofit entity does not receive in consideration for the litigation financing the payment of interest, fees, or other consideration in excess of the amount of attorney fees and litigation expenses incurred in conjunction with or in pursuit of the legal claim;

(2) any litigation financing provided by an entity engaged in commerce or business activity, but only if the entity does not:

(a) charge or collect any interest, fees, or other consideration;

(b) retain or receive any financial interest in the outcome of the legal claim; or

(c) receive any right to recovery or payment from the amount of any judgment, award, settlement, verdict, or other form of monetary relief obtained in conjunction with or in pursuit of the legal claim; or

(3) a regulated lender that does not receive, in consideration for loaning money to any person, a right to receive payment from the value of any proceeds or other consideration realized from any judgment award, settlement, verdict, or other form of monetary relief any person may receive or recover in conjunction with or in pursuit of the legal claim.

History: En. Sec. 7, Ch. 360, L. 2023; amd. Sec. 4, Ch. 413, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 4, Ch. 413, L. 2025. Amendment effective May 5, 2025.

Applicability: Section 15, Ch. 413, L. 2025, provided: "[This act] applies to litigation financing contracts entered into on or after [the effective date of this act]." Effective May 5, 2025.

31-4-119. Act violation — unenforceable contract. (1) Any violation of this part by the litigation financer renders the litigation financing contract unenforceable by the litigation financer or any successor-in-interest to the litigation financing contract.

(2) If a litigation financer charges a rate of interest that exceeds the rate of interest allowed under 31-1-107, the litigation financer shall be subject to a penalty for usury and an action to recover excessive interest as authorized under 31-1-108.

History: En. Sec. 11, Ch. 360, L. 2023.

31-4-120. Joint and several liability for costs. A litigation financer is jointly and severally liable for any award or order imposing or assessing costs or monetary sanctions against a consumer or a party's legal representative arising from or relating to any civil action, administrative proceeding, claim, or cause of action for which the litigation financer is providing litigation financing.

History: En. Sec. 9, Ch. 360, L. 2023; amd. Sec. 5, Ch. 413, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 5, Ch. 413, L. 2025. Amendment effective May 5, 2025.

Applicability: Section 15, Ch. 413, L. 2025, provided: "[This act] applies to litigation financing contracts entered into on or after [the effective date of this act]." Effective May 5, 2025.

31-4-121 through 31-4-124 reserved.

31-4-125. Regulatory oversight — rulemaking. The secretary of state is authorized to adopt rules and other policies in overseeing the practice of litigation financing consistent with this part.

History: En. Sec. 10, Ch. 360, L. 2023.

Part 2
Foreign Investment in Litigation Financing Act

Part Compiler's Comments

Effective Date: Section 14, Ch. 413, L. 2025, provided: "[This act] is effective on passage and approval." Approved May 5, 2025.

Applicability: Section 15, Ch. 413, L. 2025, provided: "[This act] applies to litigation financing contracts entered into on or after [the effective date of this act]." Effective May 5, 2025.

31-4-201. Short title. This part may be cited as the "Foreign Investment in Litigation Financing Act".

History: En. Sec. 6, Ch. 413, L. 2025.

31-4-202. Definitions. The definitions set forth in 31-4-102 apply for the purposes of this part. In addition, the following definitions apply for the purposes of this part:

(1) "Foreign adversary" means:

(a) a foreign government of a foreign country identified or designated as a foreign adversary pursuant to 15 CFR 791.4, as in effect on May 5, 2025;

(b) any political subdivision, agency, department, or political party of a foreign government identified in subsection (1)(a); or

(c) a foreign nongovernment person identified or designated by the United States secretary of commerce as a foreign adversary pursuant to 15 CFR 791.4, as in effect on May 5, 2025.

(2) "Foreign person" means:

(a) an individual who is not a citizen of the United States or is not an alien lawfully admitted for permanent residence in the United States;

(b) an entity that is not formed, organized, incorporated, or created in the United States;

(c) an entity of which a majority of the persons who own or control the entity are not citizens of the United States or are not aliens lawfully admitted for permanent residence in the United States;

(d) the government, a political subdivision, agency, department, or a political party of a country other than the United States;

(e) an entity that has a place of business in a country other than the United States and that has shares or other ownership interest held by the government or a government official of a country other than the United States; and

(f) an employee, officer, director, official, or member of an entity described in this subsection (2).

(3) "Foreign person of concern" means a person that:

(a) is formed, organized, incorporated, or created in a foreign country identified as a foreign adversary;

(b) is formed, organized, incorporated, owned, controlled, or affiliated, directly or indirectly, with a foreign adversary;

(c) maintains a personal residence or place of business in a foreign country identified as a foreign adversary; or

(d) is formed, organized, incorporated, owned, controlled, or affiliated, directly or indirectly, with a foreign person that has been:

(i) placed on the federal office of foreign assets control's specially designated nationals and blocked persons list, also known as the SDN list, as amended; or

(ii) designated by the United States secretary of state as a foreign terrorist person or organization.

History: **En. Sec. 7, Ch. 413, L. 2025.**

31-4-203. Prohibition on litigation funding by foreign adversaries or foreign persons of concern. (1) A foreign adversary or a foreign person of concern may not engage in litigation financing in this state.

(2) A foreign adversary or a foreign person of concern may not, directly or indirectly, invest in, finance, fund, or loan money to a litigation financer engaged in litigation financing in this state.

(3) A litigation financer engaged in litigation financing in this state may not, directly or indirectly:

(a) become affiliated with or maintain an affiliation with a foreign adversary or a foreign person of concern;

(b) receive or accept money or funds from a foreign adversary or a foreign person of concern; or

(c) allow a foreign adversary or a foreign person of concern to invest in, maintain an ownership interest in, or exercise any control over the litigation financer.

History: **En. Sec. 8, Ch. 413, L. 2025.**

31-4-204. Restriction on disclosure of proprietary information. A party to a civil action or administrative proceeding in this state may not disclose to or share with a foreign person, a foreign adversary, or a foreign person of concern any proprietary information received in conjunction with or in pursuit of a legal claim in this state.

History: **En. Sec. 9, Ch. 413, L. 2025.**

31-4-205. Limitations on foreign litigation funding. (1) A foreign person is prohibited from engaging in the activities set forth in subsection (2) if the foreign person directly or indirectly:

(a) engages in litigation financing;

(b) becomes affiliated with or maintains an affiliation with a litigation financer;

(c) finances, funds, or loans money to a litigation financer; or

(d) invests in, maintains an ownership interest in, or exercises any control over a litigation financer.

(2) A foreign person that engages in the activities set forth in subsection (1) may not:

(a) become affiliated with or maintain an affiliation with a foreign adversary or a foreign person of concern;

(b) receive or accept money or funds from a foreign adversary or a foreign person of concern; or

(c) allow a foreign adversary or a foreign person of concern to invest in, maintain an ownership interest in, or exercise any control over the foreign person.

History: En. Sec. 10, Ch. 413, L. 2025.

31-4-206. Registration and transparency of foreign persons. (1) A foreign person who is qualified to engage in litigation financing in this state shall comply with this chapter if the foreign person engages in litigation financing in this state.

(2) A litigation financer shall disclose in writing to the secretary of state the information set forth in subsection (3) if the litigation financer engages in any of the following:

(a) becomes affiliated with or maintains an affiliation with a foreign person;

(b) receives or accepts money or funds from a foreign person for any purpose; or

(c) allows a foreign person to invest in, maintain an ownership interest in, or exercise any control over the litigation financer.

(3) The following information must be disclosed in writing to the secretary of state:

(a) the name and address of the foreign person and the citizenship of the foreign person or the country of incorporation, formation, or registration of the foreign person; and

(b) a copy of each litigation financing contract in which the foreign person is entitled to receive any payment under the contract.

(4) The litigation financer shall provide the written notice and the information disclosure required under [this section] within 30 days after the date on which a litigation financing agreement is executed by the consumer.

History: En. Sec. 11, Ch. 413, L. 2025.

Compiler's Comments

2025 Code Commissioner Correction: In (4) the Code Commissioner substituted "this section" for "this section subsection (2)" to correct an apparent technical error during bill drafting.

31-4-205. Limitations on foreign litigation funding. (1) A foreign person is prohibited from engaging in the activities set forth in subsection (2) if the foreign person directly or indirectly:

(a) engages in litigation financing;

(b) becomes affiliated with or maintains an affiliation with a litigation financer;

(c) finances, funds, or loans money to a litigation financer; or

(d) invests in, maintains an ownership interest in, or exercises any control over a litigation financer.

(2) A foreign person that engages in the activities set forth in subsection (1) may not:

(a) become affiliated with or maintain an affiliation with a foreign adversary or a foreign person of concern;

(b) receive or accept money or funds from a foreign adversary or a foreign person of concern; or

(c) allow a foreign adversary or a foreign person of concern to invest in, maintain an ownership interest in, or exercise any control over the foreign person.

History: En. Sec. 10, Ch. 414, L. 2025.

31-4-206. Registration and transparency of foreign persons. (1) A foreign person who is qualified to engage in litigation financing in this state shall comply with this chapter if the foreign person engages in litigation financing in this state.

(2) A litigation financer shall disclose in writing to the secretary of state the information set forth in subsection (3) if the litigation financer engages in any of the following:

(a) becomes affiliated with or maintains an affiliation with a foreign person;

(b) receives or accepts money or funds from a foreign person for any purpose; or

(c) allows a foreign person to invest in, maintain an ownership interest in, or exercise any control over the litigation financer.

(3) The following information must be disclosed in writing to the secretary of state:

(a) the name and address of the foreign person and the citizenship of the foreign person or the country of incorporation, formation, or registration of the foreign person; and

(b) a copy of each litigation financing contract in which the foreign person is entitled to receive any payment under the contract.

(4) The litigation financer shall provide the written notice and the information disclosure required under [this section] within 30 days after the date on which a litigation financing agreement is executed by the consumer.

History: En. Sec. 11, Ch. 414, L. 2025.

Compiler's Comments

2025 Code Commissioner Correction: In (1) the Code Commissioner substituted "this section" for "this section subsection (2)" to correct an apparent technical error during bill drafting.

TITLE 32

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Ch.
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3. Credit Unions.
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Chapter Cross-References

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Actions against banks — limitations, 27-2-213.

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Insurance premium finance companies, Title 33, ch. 14.

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Financial institution's responsibility to provide notice when funds become available for withdrawal, 32-1-440.

32-1-101. Short title — application — purpose. (1) Parts 1 through 5 of this chapter may be known as the "Bank Act".

(2) The Bank Act is applicable to:

(a) all corporations and persons specified in 32-1-102;

(b) corporations that subject themselves to the Bank Act; and

(c) persons, partnerships, or corporations who by violating the Bank Act become subject to the penalties provided in the Bank Act.

(3) (a) The purpose of the Bank Act is to provide Montana with a sound system of state-chartered banks by providing for and encouraging the development of state-chartered banks while restricting their activities to the extent necessary to protect the interests of depositors. The purpose includes:

(i) the sound conduct of the business of banks;

(ii) the conservation of bank assets;

(iii) the maintenance of adequate reserves against deposits;

(iv) the opportunity for banks to compete with other businesses, including but not limited to other financial organizations existing under the laws of this state, other states, the United States, and foreign countries;

(v) the opportunity for banks to serve the citizens of this state;

(vi) the opportunity for banks to participate in and promote the economic progress of Montana and the United States;

(vii) the opportunity for the management of banks to exercise business judgment in conducting the affairs of their institutions; and

(viii) modernization and simplification of the law governing banking by providing that banks have all the rights and powers granted corporations, except as otherwise provided in this chapter.

(b) The Bank Act does not restrict the activities of banks for the purpose of protecting any person from competition from banks and does not confer any right or cause of action upon any competitor.

(c) The purpose contained in this subsection (3) constitutes the standards to be observed by the commissioner of banking and financial institutions in the exercise of authority under the Bank Act and provides guidelines in the construction and application of the Bank Act.

History: En. Sec. 1, Ch. 89, L. 1927; re-en. Sec. 6014.1, R.C.M. 1935; R.C.M. 1947, 5-101; amd. Sec. 4, Ch. 395, L. 1993; amd. Sec. 74, Ch. 382, L. 1997; amd. Sec. 10, Ch. 163, L. 2005.

Cross-References

Penalty for transacting business without certificate, 32-1-403.
Mutual savings and loan associations, Title 32, ch. 2.
Credit unions, Title 32, ch. 3.

32-1-102. Institutions to which chapter is applicable. (1) The word "bank" as used in this chapter means any corporation that has been incorporated to conduct the business of receiving money on deposit or transacting a trust or investment business, as defined in this chapter.

(2) The soliciting, receiving, or accepting of money or its equivalent on deposit as a regular business is doing a commercial or savings bank business, whether the deposit is made subject to check or is evidenced by a certificate of deposit, a passbook, a note, or other receipt. This section does not apply to or include money or its equivalent left in escrow or left with an agent pending investment in real estate or securities for or on account of the agent's principal.

(3) It is unlawful for any corporation, partnership, firm, or individual to engage in or transact a banking business within this state except by means of a corporation duly organized for that purpose.

(4) Banks are divided into the following classes:
(a) commercial banks;
(b) savings banks;
(c) trust companies;
(d) investment companies.

(5) This chapter does not apply to:

(a) any investment company or corporation established prior to March 8, 1927, under authority of the law of Montana not accepting, receiving, or holding money on deposit;

(b) a student financial institution, as defined in 32-1-115; or

(c) a nonprofit corporation that serves as trustee of one or more trusts in which it is expressly designated under the terms of the trust as having a present or future beneficial interest, vested or contingent.

History: En. Sec. 2, Ch. 89, L. 1927; re-en. Sec. 6014.2, R.C.M. 1935; amd. Sec. 1, Ch. 71, L. 1977; R.C.M. 1947, 5-102; amd. Sec. 75, Ch. 382, L. 1997; amd. Sec. 3, Ch. 340, L. 2003; amd. Sec. 11, Ch. 163, L. 2005; amd. Sec. 143, Ch. 264, L. 2013.

Cross-References

Agency, Title 28, ch. 10.
U.C.C. — bank defined, 30-1-201.
Definition of regulated lender, 31-1-111.
Consolidation or merger of banks, 32-1-371.
Penalty for transacting business without certificate, 32-1-403.
Dissolution, closing, and liquidation — bank defined, 32-1-561.

32-1-103. Repealed. Sec. 4, Ch. 15, L. 2005.

History: En. Sec. 31, Ch. 89, L. 1927; re-en. Sec. 6014.35, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-510.

32-1-104. Number of persons necessary to form corporation. Corporations may be formed by any number of natural persons or by a corporation or other entity authorized to own or control banks and organized under the laws of this state to conduct, as provided in this chapter, the businesses mentioned in 32-1-102.

History: En. Sec. 3, Ch. 89, L. 1927; re-en. Sec. 6014.3, R.C.M. 1935; R.C.M. 1947, 5-103; amd. Sec. 1, Ch. 117, L. 1997.

32-1-105. Commercial bank defined. The term "commercial bank" means any bank authorized by law to:

(1) receive deposits of money;
(2) deal in commercial paper or make loans on commercial paper;
(3) lend money on real or personal property;
(4) engage in business activities directly or indirectly through affiliates or subsidiaries;

(5) discount bills, notes, or other commercial papers; and

(6) buy and sell securities, gold and silver bullion, foreign coins, or bills of exchange.

History: **En. Subd. a, Sec. 4, Ch. 89, L. 1927; re-en. Sec. 6014.4, R.C.M. 1935; R.C.M. 1947, 5-104; amd. Sec. 1, Ch. 129, L. 1981; amd. Sec. 1, Ch. 100, L. 1999.**

Cross-References

U.C.C. — bank defined, 30-1-201.
U.C.C. — negotiable instruments, Title 30, ch. 3.
Consolidation or merger of banks, 32-1-371.
Disability insurance, 33-1-207.
Life insurance, 33-1-208.

32-1-106. Savings bank defined. The term "savings bank" means a bank organized only for the purpose of accumulating and loaning the funds of its members, stockholders, and depositors and which may:

(1) loan and invest the funds thereof;

(2) receive deposits of money; loan, invest, and collect the same with interest; and repay depositors with or without interest;

(3) sell credit life and disability insurance on loans to its borrowers;

(4) invest said funds and moneys in such property, securities, and obligations as may be prescribed by this chapter; and

(5) declare and pay:

(a) dividends on its general deposits; and

(b) a stipulated rate of interest on deposits made for a stated period or upon special terms.

History: **En. Subd. b, Sec. 4, Ch. 89, L. 1927; re-en. Sec. 6014.5, R.C.M. 1935; R.C.M. 1947, 5-105; amd. Sec. 2, Ch. 129, L. 1981.**

Cross-References

U.C.C. — bank defined, 30-1-201.
Legal interest, 31-1-106.
Interest rate allowed by agreement, 31-1-107.
Consolidation or merger of banks, 32-1-371.
Investment of capital of savings banks, 32-1-421.
Disability insurance, 33-1-207.
Life insurance, 33-1-208.

32-1-107. Trust company defined — purposes for which may be formed. The term "trust company" means any corporation that is incorporated under the laws of this state for any one or more of the following purposes:

(1) to receive money in trust and to accumulate the money at rates of interest as may be obtained or agreed upon or to allow interest on the money as may be agreed upon;

(2) to accept and execute all trusts and perform the duties committed to them by any person or by any corporations or may be committed or transferred to them by order of any of the courts of record of this state or any other state or of the United States;

(3) to take and accept by grant, assignment, transfer, devise, or bequest and hold any real or personal estate or trust created in accordance with the laws of this state or any other state or of the United States and execute the legal trusts in regard to the same on the terms as may be declared, established, or agreed upon in regard to the estate or trust;

(4) to act as agent for the investment of money for other persons or corporations and as agents for persons and corporations for the purpose of issuing, registering, transferring, or countersigning the certificates of stock, bonds, or other evidence of debt of any corporation, association, municipality, state, or public authority as may be agreed upon;

(5) except as provided in Title 72, chapter 40, part 1, to accept from and execute trusts for married persons in respect to their individual property, whether real or personal, and act as agents for them in the management of the property and generally to have and exercise powers as are usually had and exercised by trust companies;

(6) except as provided in Title 72, chapter 40, part 1, to act as trustee, assignee, or receiver in all cases where it is lawful for any court of record, officer, corporation, or person to appoint a trustee, assignee, or receiver and to be appointed a trustee, assignee, or receiver and to be appointed, commissioned, and act as administrator of any estate, executor of any last will and testament of any deceased person, and as guardian of the person and estate of any minor or

minors or of the estate of any person of unsound mind, spendthrift, habitual drunkard, or other persons disqualified or unable to manage their estates;

(7) to loan money upon unencumbered real estate, collateral, or personal security and execute and issue notes and debentures payable at a future date and to pledge its mortgages upon real estate and other securities as security for the notes and debentures;

(8) to buy and sell:

(a) government, state, county, municipal, and other bonds. The trust company may invest in United States obligations either directly or in the form of securities of or other interests in an open-end or closed-end management type investment company or investment trust registered under the Investment Company Act of 1940 (15 U.S.C. 80a-1 through 80a-64), as amended, if:

(i) the portfolio of the investment company or investment trust is limited to United States government obligations and repurchase agreements fully collateralized by United States government obligations; and

(ii) the investment company or investment trust takes delivery of the collateral for any repurchase agreement, either directly or through an authorized custodian.

(b) all kinds of negotiable, nonnegotiable, and commercial paper, stocks, and other investment securities; and

(c) gold and silver bullion, foreign coins, bills of exchange, and foreign and domestic exchange;

(9) to accept, receive, and hold money on deposit, payable either on time or on demand, with or without interest, as may be agreed upon with the depositors; to take and receive from any individual or corporation on deposit for safekeeping and storage, gold and silver plate, jewelry, stocks, securities, and other valuable and personal property; to collect coupons, interest, and dividends on securities described in this section; and to rent out the use of safes and other receptacles on their premises upon terms and for compensation as may be agreed upon.

History: En. Subd. c, Sec. 4, Ch. 89, L. 1927; re-en. Sec. 6014.6, R.C.M. 1935; amd. Sec. 18, Ch. 293, L. 1975; R.C.M. 1947, 5-106; amd. Sec. 2, Ch. 137, L. 1989; amd. Sec. 19, Ch. 325, L. 2021.

Cross-References

U.C.C. — negotiable instruments, Title 30, ch. 3.
U.C.C. — investment securities, Title 30, ch. 8.
Legal interest, 31-1-106.
Interest rate allowed by agreement, 31-1-107.
Consolidation or merger of banks, 32-1-371.
Business corporations, Title 35, ch. 14.
Trust Code, Title 72, ch. 38.

32-1-108. Investment company defined — purposes for which may be formed. The term "investment company" means any corporation which is incorporated under the laws of this state for any one or more of the following purposes:

(1) to receive moneys in trust and to accumulate the same at such rates of interest as may be obtained or agreed upon or to allow such interest as may be agreed upon and to issue and sell its contracts or certificates of indebtedness, directly or through an agent or broker, bearing fixed rates of interest, in whole or in part, with participation or nonparticipation in the profits of the corporation and maturing at fixed periods of time, or otherwise, as may be fully set forth in said contracts or certificates;

(2) to buy and sell government, state, county, municipal, and other bonds and all kinds of negotiable and nonnegotiable and commercial paper, stocks, and other investment securities;

(3) to accept, receive, and hold money on deposit, payable either on time or on demand, with or without interest, as may be agreed upon with depositors, and to collect coupons, interest, and dividends on securities described in (2).

History: En. Subd. d, Sec. 4, Ch. 89, L. 1927; re-en. Sec. 6014.7, R.C.M. 1935; R.C.M. 1947, 5-107.

Cross-References

U.C.C. — negotiable instruments, Title 30, ch. 3.
U.C.C. — investment securities, Title 30, ch. 8.
Legal interest, 31-1-106.
Interest rate allowed by agreement, 31-1-107.
Consolidation or merger of banks, 32-1-371.
Business corporations, Title 35, ch. 14.

32-1-109. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Acquire" means:

(a) the direct or indirect purchase or exchange of stock;

(b) the direct or indirect purchase of assets and liabilities; or

(c) a merger.

(2) "Acquiring party" means the person acquiring control of a bank through the purchase of stock.

(3) "Affiliate" has the meaning given in 12 U.S.C. 1841(k).

(4) "Bank holding company" means a bank holding company or a financial holding company registered under the federal Bank Holding Company Act of 1956, as amended, regardless of where the entity is located or has its headquarters.

(5) "Branch" means:

(a) in the case of a bank, a banking house, other than the main banking house, maintained and operated by a bank doing business in the state and at which deposits are received, checks are paid, or money is lent. The term does not include a satellite terminal as defined in 32-6-103, an interactive teller machine as defined in this section, a loan production office, or the office of an affiliated depository institution acting as an agent under 12 U.S.C. 1828.

(b) in the case of a trust company, any office at which trust services are provided.

(6) "Capital", "capital stock", and "paid-in capital" mean that fund for which certificates of stock are issued to stockholders.

(7) "Consolidate" and "merge" mean the same thing and may be used interchangeably in this chapter.

(8) "Control" means:

(a) ownership of, authority over, or power to vote, directly or indirectly, 25% or more of any class of voting security;

(b) authority in any manner over the election of a majority of directors; or

(c) power to exercise, directly or indirectly, a controlling influence over management and policies.

(9) "Demand deposits" means all deposits, the payment of which can legally be required when demanded.

(10) "Department" means the department of administration provided for in Title 2, chapter 15, part 10.

(11) "Depository institution" means a bank or savings association organized under the laws of a state or the United States.

(12) "Division" means the division of banking and financial institutions of the department.

(13) "Doing business in this state" means located in this state or having a physical branch bank location in this state.

(14) "Headquarters" means the state in which the activities of a bank holding company or a company controlling the bank holding company are principally conducted within the meaning of the federal Bank Holding Company Act of 1956, as amended.

(15) "Insured depository institution" means a bank or savings association in which the deposits are insured by the federal deposit insurance corporation.

(16) "Interactive teller machine" means an automated, unstaffed banking facility owned or operated by, or operated exclusively for, a bank that is equipped to enable existing customers to initiate an interactive session with remotely located bank personnel. Customers must also be able to perform core banking transactions at the machine without the involvement of bank personnel and must have the sole discretion to initiate or terminate interactive sessions with bank personnel.

(17) "Loan production office" means a staffed facility, other than a branch, that provides lending-related services to the public, including loan information and applications.

(18) "Located in this state" means:

(a) in the case of a bank, that the bank is either organized under the laws of this state or is a federally chartered bank whose organizational certificate identifies an address in this state as the principal place at which the business of the federally chartered bank is conducted; and

(b) in the case of a bank holding company, that the entity, partnership, or trust is organized under the laws of this state.

(19) "Main banking house" means the designated principal place of business of a bank.

(20) "Net earnings" means the excess of the gross earnings of a bank over expenses and losses chargeable against those earnings during any 1 year.

(21) "Principal shareholder" means a person who directly or indirectly owns or controls, individually or through others, more than 10% of any class of voting stock.

(22) "Profit and loss account" or "profit and loss" means that account carried on the books of the bank into which all earnings accounts and recoveries are closed, thus exhibiting "gross earnings", and against which all loss and other disbursement items are charged, revealing "net earnings", which are then properly closed to "undivided profits accounts" or "undivided profits", out of which dividends are paid and reserves set aside.

(23) "Regional banking organization" means a bank organized in this state that is owned by an entity with consolidated total assets between $10 billion and $50 billion and that has subsidiaries operating in one or more states but not nationwide.

(24) "Savings association" means a savings association or savings bank organized under the laws of the United States or a building and loan association, savings and loan association, or similar entity organized under the laws of a state.

(25) (a) "Service provider" means an individual or person that provides one or more of the following services to a depository institution:

(i) data processing services;

(ii) activities supporting financial services, including but not limited to lending, funds transfer, fiduciary activities, trading activities, and deposit taking;

(iii) internet-related services, including but not limited to web services and electronic bill payments, mobile applications, system and software development and maintenance, and security monitoring; and

(iv) activities related to the business of banking.

(b) The term does not include:

(i) an individual or person that provides telecommunications service, internet access service, internet transport services, voice over internet protocol service, or other internet protocol-enabled service; or

(ii) a general audience internet or communications platform.

(26) "Shell bank" means a bank organized solely for the purpose of, and that does not conduct any banking business prior to, acquiring control of, merging with, or acquiring all or substantially all of the assets of an existing bank or savings association.

(27) "Subsidiary" means a company 25% or more of whose voting shares or equity interests are owned and controlled by a bank.

(28) "Surplus" means a fund paid in or created under this chapter by a bank from its net earnings or undivided profits that, when set apart and designated as surplus, is not available for the payment of dividends and cannot be used for the payment of expenses or losses so long as the bank has undivided profits.

(29) "Tier 1 leverage ratio" means the ratio of tier 1 capital to average total assets as defined in 12 CFR 324.10(b)(4).

(30) "Time deposits" means all deposits, the payment of which cannot legally be required within 7 days.

(31) "Undivided profits" means the credit balance of the profit and loss account of a bank.

History: En. Sec. 5, Ch. 89, L. 1927; re-en. Sec. 6014.9, R.C.M. 1935; amd. Sec. 1, Ch. 431, L. 1975; R.C.M. 1947, 5-109; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 1, Ch. 483, L. 1983; amd. Sec. 2, Ch. 75, L. 1985; amd. Sec. 1, Ch. 322, L. 1989; amd. Sec. 5, Ch. 395, L. 1993; amd. Sec. 2, Ch. 117, L. 1997; amd. Sec. 2, Ch. 100, L. 1999; amd. Sec. 1, Ch. 36, L. 2001; amd. Sec. 75, Ch. 483, L. 2001; amd. Sec. 1, Ch. 49, L. 2013; amd. Sec. 7, Ch. 75, L. 2019; amd. Sec. 9, Ch. 23, L. 2023; amd. Sec. 1, Ch. 120, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 1, Ch. 120, L. 2025. Amendment effective October 1, 2025.

Cross-References

Demand or time deposits, 32-1-445.

32-1-110. Punishment. When no other punishment is provided, a person willfully or knowingly violating parts 1 through 5 of this chapter is guilty of a misdemeanor. Upon information furnished by the department, the attorney general shall sue to enforce parts 1 through 5 of this chapter.

History: En. Sec. 143, Ch. 89, L. 1927; re-en. Sec. 6014.153, R.C.M. 1935; amd. Sec. 61, Ch. 431, L. 1975; R.C.M. 1947, 5-1123.

Cross-References

Attorney General — general duties, 2-15-501.
Penalty for transacting business without certificate, 32-1-403.
Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.
Misdemeanor — when no penalty specified, 46-18-212.

32-1-111. Attachments prohibited. No property owned by any bank organized under the laws of the state of Montana shall be subject to attachment.

History: En. Sec. 96, Ch. 89, L. 1927; re-en. Sec. 6014.107, R.C.M. 1935; R.C.M. 1947, 5-1023.

Cross-References

Prejudgment attachment, Title 27, ch. 18.

32-1-112. Applicability of corporation law. (1) Except as provided in subsection (2), the provisions of Title 35, chapter 14, apply to banks unless a section in this title or a rule or order issued under this chapter is inconsistent with Title 35, chapter 14.

(2) The provisions of 35-14-301, 35-14-302(4) through (10), 35-14-401(1), 35-14-621(2), Title 35, chapter 14, part 14, and 35-14-1601 do not apply to banks.

History: En. Sec. 13, Ch. 395, L. 1993; amd. Sec. 5, Ch. 71, L. 2005; amd. Sec. 227, Ch. 271, L. 2019; amd. Sec. 10, Ch. 23, L. 2023.

32-1-113 and 32-1-114 reserved.

32-1-115. Student financial institution defined — obligations of minor — applicability of laws. (1) The term "student financial institution" means a financial institution that:

(a) is located at a school or a location where educational services are provided;

(b) is operated as a financial literacy educational program;

(c) is operated by one or more state-chartered or federally chartered financial institutions, limited to a state or national bank, a state or federal savings and loan association, a trust company, an investment company, or a state or federal credit union;

(d) does not provide services to the general public; and

(e) conducts each program in a manner consistent with safe and sound banking practices and compliant with state law.

(2) To operate a student financial institution, a state-chartered bank, savings and loan association, trust company, investment company, or credit union shall provide written notice to the department.

(3) Establishing a student financial institution does not require a branch application.

(4) With regard to the operation of a student financial institution, the obligations of a minor pertaining to borrowing money, cashing checks, and making deposits have the same force and effect as though they were the obligations of a person over the age of majority.

(5) The provisions of 32-1-102, 32-1-402, 32-3-106, and this section apply to a student financial institution established pursuant to this section, but other provisions of Title 32, chapters 1 through 3, or any other provision of state law that regulates banks, credit unions, other financial institutions, or currency exchanges do not apply.

History: En. Sec. 1, Ch. 340, L. 2003; amd. Sec. 8, Ch. 75, L. 2019.

Part 2

State-Chartered Banks and Functions of Department of Administration

32-1-201. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. Sec. 3, Ch. 420, L. 1973; amd. Sec. 11, Ch. 71, L. 1977; amd. Sec. 2, Ch. 453, L. 1977; R.C.M. 1947, 5-609; amd. Sec. 3, Ch. 274, L. 1981; amd. Sec. 6, Ch. 474, L. 1981; amd. Sec. 1, Ch. 9, L. 1987; amd. Sec. 7, Ch. 395, L. 1993; amd. Sec. 76, Ch. 483, L. 2001.

32-1-202. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. Sec. 4, Ch. 420, L. 1973; amd. Sec. 22, Ch. 431, L. 1975; amd. Sec. 12, Ch. 71, L. 1977; R.C.M. 1947, 5-610; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 2, Ch. 322, L. 1989; amd. Sec. 8, Ch. 395, L. 1993; amd. Sec. 2, Ch. 265, L. 1995; amd. Sec. 3, Ch. 117, L. 1997; amd. Sec. 76, Ch. 382, L. 1997; amd. Sec. 12, Ch. 163, L. 2005; amd. Sec. 9, Ch. 75, L. 2019.

32-1-203. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. Sec. 5, Ch. 420, L. 1973; amd. Sec. 23, Ch. 431, L. 1975; amd. Sec. 13, Ch. 71, L. 1977; R.C.M. 1947, 5-611; amd. Sec. 3, Ch. 322, L. 1989; amd. Sec. 4, Ch. 117, L. 1997.

32-1-204. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. Sec. 6, Ch. 420, L. 1973; amd. Sec. 24, Ch. 431, L. 1975; R.C.M. 1947, 5-612; amd. Sec. 1, Ch. 567, L. 1987; amd. Sec. 3, Ch. 265, L. 1995; amd. Sec. 5, Ch. 117, L. 1997; amd. Sec. 10, Ch. 75, L. 2019.

32-1-205. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. Sec. 7, Ch. 420, L. 1973; R.C.M. 1947, 5-613; amd. Sec. 139, Ch. 575, L. 1981.

32-1-206. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. Sec. 8, Ch. 420, L. 1973; R.C.M. 1947, 5-614; amd. Sec. 1008, Ch. 56, L. 2009.

32-1-207 through 32-1-210 reserved.

32-1-211. Examination and supervision by department — division of banking and financial institutions — commissioner — rulemaking. (1) The department shall:

(a) exercise constant supervision over the books and affairs of all banks and trust companies doing business in this state; and

(b) investigate the methods of operation and conduct of business of the banks and trust companies and their systems of accounting to ascertain whether the methods and systems are in accordance with law and sound banking principles.

(2) Except as provided in subsection (3), the department shall:

(a) examine, at least once every 24 months, each bank or trust company and verify the assets and liabilities of each and investigate the character and value of the assets of each as to ascertain with reasonable certainty that the values are correctly carried on the books; and

(b) submit in writing to the examined bank or trust company a report of the examination's findings no later than 60 days after the completion of the examination.

(3) The department may accept as the examination required by subsection (2) the findings or results of an examination of a bank, trust company, or service provider that was made by a federal or a state regulatory agency or insuring agency of the United States authorized to make the examination.

(4) Whenever a depository institution or its subsidiary or the depository institution's affiliate, any of which is subject to examination by the department, causes any of the services listed for a service provider in 32-1-109 to be performed for itself, by contract or otherwise, the performance is subject to regulation and examination by the department to the same extent as if the services were performed by the depository institution itself.

(5) The department may:

(a) enter into joint examination or joint enforcement actions with other bank regulatory agencies having concurrent jurisdiction over a bank, trust company, or service provider;

(b) enter into agreements with any depository institution regulatory agency that has concurrent jurisdiction over a bank, trust company, or service provider to:

(i) engage the services of the agency's examiners at a reasonable rate of compensation; or

(ii) provide the services of the department's examiners to the agency at a reasonable rate of compensation;

(c) disclose to a bank information about a service provider of that bank.

(6) The department may in the performance of its official enforcement duties:

(a) examine under oath any of the officers, directors, agents, clerks, customers, or depositors of a bank or trust company regarding the affairs and business of the bank or trust company; and

(b) issue subpoenas and administer oaths.

(7) In case of a refusal to obey a subpoena issued by the department, the refusal may be reported to the district court of the district in which the bank or trust company is located. The court shall enforce obedience to the subpoena in the manner provided by law for enforcing obedience to the process of the court.

(8) In all matters relating to its official duties, the department has the same power possessed by courts of law to issue subpoenas and have them served and enforced.

(9) All officers, directors, agents, and employees of banks or trust companies doing business under this chapter and all persons having dealings with or knowledge of the affairs or methods of a bank or trust company shall:

(a) at all times afford reasonable facilities for the examinations;

(b) make returns and reports to the department as required by the department;

(c) attend hearings and answer under oath the department's inquiries;

(d) produce and exhibit any books, accounts, documents, and property the department desires to inspect; and

(e) in all things aid the department in the performance of its duty.

(10) There is within the department a division of banking and financial institutions. The head of the division is the commissioner of banking and financial institutions, who shall exercise supervision and control over the activities and employees of the division. The position of commissioner is an exempt position as provided in 2-18-103. The commissioner must be hired by and serve at the pleasure of the director of the department.

(11) The department may adopt rules to implement this section.

History: En. Sec. 71, Ch. 89, L. 1927; re-en. Sec. 6014.75, R.C.M. 1935; amd. Sec. 30, Ch. 431, L. 1975; R.C.M. 1947, 5-901; amd. Sec. 2, Ch. 9, L. 1987; amd. Sec. 1, Ch. 199, L. 1989; amd. Sec. 6, Ch. 395, L. 1993; amd. Sec. 11, Ch. 75, L. 2019; amd. Sec. 11, Ch. 23, L. 2023.

Cross-References

Oaths, Title 1, ch. 6, part 1.
Subpoenas, Title 26, ch. 2, part 1.
Consumer protection — Department authority, 30-14-114.
Unfair trade practices — investigations, 30-14-221.
Penalty for transacting business without certificate, 32-1-403.
Examination by corporation — accepted when, 32-1-605.
Mutual savings and loan associations — Department responsibility, Title 32, ch. 2, part 7.
Credit unions — examinations, 32-3-203.
Access to records — witnesses, 32-5-404.

32-1-212. Conflicts of interest — definition — rulemaking. (1) The commissioner and any deputy commissioner may not be, directly or indirectly, interested in any entity chartered or supervised by the department.

(2) The commissioner, any deputy commissioner, or any employee of the division, including a bank examiner, may not borrow money from an entity chartered or supervised by the department unless the extension of credit:

(a) is made on substantially the same terms as those prevailing at the time for comparable transactions by the financial institution with persons who are not employed by the division; and

(b) does not involve more than the normal risk of repayment or present other unfavorable features.

(3) For the purposes of this section, the phrase "substantially the same terms" includes interest rates and collateral and credit underwriting procedures that are not less stringent than those prevailing at the time for comparable transactions by the lender as for other borrowers who are not employed by the division.

(4) The department shall adopt rules to implement this section.

History: En. Sec. 58, Ch. 89, L. 1927; re-en. Sec. 6014.62, R.C.M. 1935; amd. Sec. 20, Ch. 431, L. 1975; amd. Sec. 10, Ch. 71, L. 1977; R.C.M. 1947, 5-604; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 77, Ch. 483, L. 2001; amd. Sec. 2, Ch. 49, L. 2013; amd. Sec. 12, Ch. 75, L. 2019.

Cross-References

Public employees — code of ethics, Title 2, ch. 2, part 1.

32-1-213. Payments to be made by banks, investment companies, and trust companies. Each bank, trust company, or investment company under the supervision of the department shall pay to the department fees set by the department by rule to recover all of the costs of administering the program for the supervision of banks, trust companies, and investment companies. The department may amend the rule setting the fees on or before June 1 and December 1 of each year. The funds collected must be deposited in the state special revenue fund for the use of the department in its examination function.

History: En. Sec. 73, Ch. 89, L. 1927; amd. Sec. 1, Ch. 167, L. 1929; re-en. Sec. 6014.82, R.C.M. 1935; amd. Sec. 1, Ch. 59, L. 1953; amd. Sec. 1, Ch. 141, L. 1959; amd. Sec. 1, Ch. 256, L. 1971; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-908; amd. Sec. 1, Ch. 289, L. 1979; amd. Sec. 1, Ch. 507, L. 1983; amd. Sec. 1, Ch. 600, L. 1985; amd. Sec. 6, Ch. 117, L. 1997.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.
State finance — fund structure, 17-2-102.

32-1-214. Special examination defined. A special examination is an examination made by the department otherwise than in the ordinary routine of the department because, in its opinion, the condition of the bank requires the examination or an examination made at the request of the board of directors or stockholders of a bank.

History: En. Sec. 92, Ch. 89, L. 1927; re-en. Sec. 6014.103, R.C.M. 1935; amd. Sec. 35, Ch. 431, L. 1975; amd. Sec. 18, Ch. 71, L. 1977; R.C.M. 1947, 5-1019.

Cross-References

Examinations by corporation — accepted when, 32-1-605.
Credit unions — examinations, 32-3-203.

32-1-215. Special examinations and fees — report within 120 days. Special examinations may be made of a bank, trust company, investment company, building and loan association, or credit union when in the judgment of the department it is considered necessary, and the special examination shall be charged for at a rate that equals the department's actual costs for examiner wages and travel expenses. All special examination fees or charges shall be paid at the conclusion of the examination, and the moneys collected by the department shall be paid to the state treasurer for the credit of the state special revenue fund for the use of the department in its examination function. The department shall submit in writing to the examined bank a report of the examination's findings no later than 120 days after the completion of the examination.

History: En. Sec. 2, Ch. 167, L. 1929; re-en. Sec. 6014.84, R.C.M. 1935; amd. Sec. 1, Ch. 58, L. 1953; amd. Sec. 1, Ch. 137, L. 1955; amd. Sec. 1, Ch. 180, L. 1959; amd. Sec. 222, Ch. 147, L. 1963; amd. Sec. 22, Ch. 249, L. 1967; amd. Sec. 5, Ch. 256, L. 1971; amd. Sec. 31, Ch. 431, L. 1975; R.C.M. 1947, 5-910; amd. Sec. 2, Ch. 600, L. 1985; amd. Sec. 2, Ch. 199, L. 1989.

Cross-References

Mutual savings and loan associations — examinations and supervision by Department, 32-2-701.
Credit unions — examinations, 32-3-203.

32-1-216. Examination at request of directors. When requested in writing, upon the authority of a majority of the board of directors of any bank, to make an examination of such bank, the department shall do so.

History: En. Sec. 93, Ch. 89, L. 1927; re-en. Sec. 6014.104, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1020.

Cross-References

Board of directors — qualifications, tenure, and vacancies, 32-1-322.

32-1-217. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 98, Ch. 89, L. 1927; re-en. Sec. 6014.109, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1025.

32-1-218. Department to make rules. (1) The department may promulgate reasonable rules and orders concerning bookkeeping and accounting by state banks, including the keeping of reasonable credit information, information in connection with assets, or information in connection with charged-off items.

(2) The department may adopt uniform rules to govern the examination and reports of banks and trust companies and prescribe the form in which banks and trust companies report their assets, liabilities, and reserves.

(3) The department may promulgate reasonable rules concerning applications for and determinations on applications for the formation, relocation, closure, and sale of branch banks and applications for the formation, consolidation, and merger of shell banks.

(4) The department may adopt rules, issue orders and declaratory statements, disseminate information, and exercise its discretion to effectuate the purposes, policies, and provisions of this chapter.

History: (1)En. Sec. 100, Ch. 89, L. 1927; re-en. Sec. 6014.111, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; amd. Sec. 20, Ch. 71, L. 1977; Sec. 5-1027, R.C.M. 1947; (2)En. Sec. 91, Ch. 89, L. 1927; re-en. Sec. 6014.102, R.C.M. 1935; amd. Sec. 34, Ch. 431, L. 1975; Sec. 5-1018, R.C.M. 1947; R.C.M. 1947, 5-1018, 5-1027; amd. Sec. 9, Ch. 395, L. 1993; amd. Sec. 7, Ch. 117, L. 1997.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

32-1-219. Reliance on order — limit on liability. A person acting in good faith reliance upon a rule, order, or declaratory statement issued by the division is not subject to any criminal, civil, or administrative liability for the action if a subsequent decision by a court of competent jurisdiction invalidates the rule, order, or declaratory statement. In the case of an order or declaratory statement that is not of general application, only the person to whom the order or declaratory statement was issued is entitled to rely upon it, unless a third person is dealing with material facts or circumstances that are substantially the same as those upon which the order or declaratory statement was based.

History: En. Sec. 10, Ch. 395, L. 1993.

32-1-220. Access to holding companies and affiliated entities. The division may review the books and affairs of a bank holding company operating under the Bank Holding Company Act of 1956 during the course of a safety and soundness examination of the bank holding company's subsidiary bank to the extent that the records pertain to the operations and financial condition of the subsidiary bank or to the holding company's indebtedness. The authority granted in this section does not authorize the division to regulate or charge assessments to a bank holding company.

History: En. Sec. 11, Ch. 395, L. 1993; amd. Sec. 1, Ch. 148, L. 1997; amd. Sec. 1, Ch. 49, L. 2011.

32-1-221. Regional banking organizations — department authority. (1) Notwithstanding 32-1-211(2)(b), the department shall submit to a regional banking organization a report of the examination findings no later than 90 days after the completion of the examination.

(2) The department has the same examination authority over the bank holding company of a regional banking organization as the department has over the regional banking organization.

(3) The department may:

(a) participate in examinations of bank holding companies of regional banking organizations with federal financial institution regulatory agencies and one or more state's financial regulatory departments; and

(b) take an enforcement action against the bank holding company of a regional banking organization pursuant to this chapter if the department considers the action to be necessary or appropriate to carry out its responsibilities under this chapter or to ensure compliance with the laws of this state.

(4) Notwithstanding 32-1-322, at least one-third of the board of directors of a regional banking organization must be residents of Montana.

History: En. Sec. 1, Ch. 75, L. 2019.

32-1-222. Loan production office — rulemaking authority. (1) A bank may:

(a) establish and maintain a loan production office only after approval by the department; or

(b) relocate or close a loan production office after giving notice to its customers and the department.

(2) The department may adopt rules to implement this section.

History: En. Sec. 2, Ch. 75, L. 2019; amd. Sec. 12, Ch. 23, L. 2023.

32-1-223 through 32-1-230 reserved.

32-1-231. Reports to department. (1) A bank shall make to the department regular call reports at least three times each year according to the form that may be prescribed by the department, verified by oath or affirmation of the president, vice president, or cashier of the bank and attested by the signature of at least two of the directors other than the subscribing officer.

(2) Each call report must exhibit in detail, and under appropriate schedules, the resources and liabilities of the bank at the close of business on any past day specified by the department.

The "past day specified" by the department, under the provisions of this section, must be the day designated by the comptroller of currency of the United States for reports of national banking associations.

(3) The call report must be transmitted to the department within 30 days after the past day specified under subsection (2). A bank's successful and timely electronic transmittal of its call report to the applicable federal banking regulator or authority satisfies the bank's obligation to transmit the report to the department. The original signature page of the bank's call report that complies with subsection (1) must be permanently retained by the bank and available for the department's review. A nondepository trust company that is not insured by the federal deposit insurance corporation shall transmit its call report directly to the department in hard copy or imaged form.

History: En. Secs. 61, 64, Ch. 89, L. 1927; re-en. Secs. 6014.65, 6014.68, R.C.M. 1935; amd. Secs. 25, 170, Ch. 431, L. 1975; R.C.M. 1947, 5-701, 5-704; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 1, Ch. 186, L. 1985; amd. Sec. 1, Ch. 64, L. 1995; amd. Sec. 1, Ch. 12, L. 2015.

Cross-References

Publication of legal notices, Title 18, ch. 7, part 2.
Mutual savings and loan associations — reports to Department, 32-2-706.
Credit unions — reports, 32-3-202.

32-1-232. Report of declaration of dividend. In addition to the call report required by 32-1-231, a bank shall report to the department within 30 days after declaring a dividend, showing the amount of the dividend and the amount of net earnings in excess of the dividend. The report must be attested as provided in 32-1-231.

History: En. Sec. 62, Ch. 89, L. 1927; re-en. Sec. 6014.66, R.C.M. 1935; amd. Sec. 26, Ch. 431, L. 1975; amd. Sec. 14, Ch. 71, L. 1977; R.C.M. 1947, 5-702; amd. Sec. 2, Ch. 12, L. 2015; amd. Sec. 13, Ch. 75, L. 2019.

Cross-References

Dividends, surplus, losses, and bad debts, 32-1-452.

32-1-233. Special reports to department. (1) In addition to the information obtained from the call report required by 32-1-231, the department may also require a bank to furnish a special report in writing, verified as required by 32-1-231, when in its judgment the special report is necessary to inform it fully of the actual financial condition and affairs of the bank. A willfully false statement in the report is perjury and must be punished accordingly.

(2) Each bank shall file a report of service and technology providers containing the information as set forth by the department by rule by July 31 of each year.

(3) A bank shall report an incident that allowed unauthorized access to customer data or interruption of customer services to the department immediately following discovery and without unreasonable delay.

History: En. Sec. 63, Ch. 89, L. 1927; re-en. Sec. 6014.67, R.C.M. 1935; amd. Sec. 27, Ch. 431, L. 1975; R.C.M. 1947, 5-703; amd. Sec. 3, Ch. 12, L. 2015; amd. Sec. 13, Ch. 23, L. 2023.

Cross-References

Fraud by director, officer, or employee, 32-1-464.
Penalty for receiving deposits when insolvent or for making false statements, 32-1-505.
Perjury, 45-7-201.
False swearing, 45-7-202.
Unsworn falsification to authorities, 45-7-203.

32-1-234. Confidentiality — penalties. (1) (a) Reports and statements under 32-1-211, 32-1-215, 32-1-216, 32-1-221, 32-1-232, and 32-1-233 are confidential. Except for information made public by the federal deposit insurance corporation or other federal banking authority's publicly accessible website, any information contained in the reports and statements, the source documents from which this information is derived, and communications concerning reports and statements are confidential. Except as provided in subsection (1)(b), confidential information may not be disclosed to persons who are not officially associated with the department and may be used by the department only to further its official duties.

(b) The department may exchange information with federal financial institution regulatory agencies and with the financial regulatory departments of other states. The department may furnish reports of its examination findings under 32-1-211, 32-1-215, and 32-1-216 to a federal home loan bank, as defined in the Federal Home Loan Bank Act of 1932, 12 U.S.C. 1422. The department may furnish information to the legislative auditor for use in pursuit of official duties. A prosecuting official may obtain the information by court order.

(2) Any knowledge or information gained or discovered by the department in pursuance of its powers or duties is confidential information of the department. The information may not, except as provided in subsection (1)(b), be disclosed to any person not officially associated with the department. The information must be used by the department only to further its official duties.

(3) An employee or agent of the department who violates this section or willfully makes a false official report as to the condition of a bank must be removed from office and is also guilty of a felony. On conviction, the person shall be fined an amount not exceeding $1,000, imprisoned in a state correctional facility for a term not exceeding 5 years, or both.

History: **En. Secs. 65, 85, Ch. 89, L. 1927; re-en. Secs. 6014.69, 6014.96, R.C.M. 1935; amd. Secs. 28, 33, Ch. 431, L. 1975; R.C.M. 1947, 5-705, 5-1012; amd. Sec. 12, Ch. 395, L. 1993; amd. Sec. 4, Ch. 12, L. 2015; amd. Sec. 1, Ch. 68, L. 2019; amd. Sec. 14, Ch. 75, L. 2019; amd. Sec. 14, Ch. 23, L. 2023.**

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.
Public records generally, Title 2, ch. 6, part 10.
Fraud by director, officer, or employee, 32-1-464.
Penalty for receiving deposits when insolvent or for making false statements, 32-1-505.
Classification of offenses, 45-1-201.
Felony defined, 45-2-101.

32-1-235. Repealed. Sec. 6, Ch. 12, L. 2015.

History: **En. Sec. 66, Ch. 89, L. 1927; re-en. Sec. 6014.70, R.C.M. 1935; R.C.M. 1947, 5-706; amd. Sec. 2, Ch. 186, L. 1985.**

32-1-236. False statements and entries considered felony. Every officer or other person authorized by this chapter who willfully and knowingly makes any false statement of facts, statement of account, or report and every officer, agent, or clerk of any bank who willfully and knowingly makes any false entries in the books of such bank or knowingly subscribes or exhibits false papers with the intent to deceive any person authorized to examine such bank and every person authorized by the provisions of this chapter to make statements or reports who willfully and knowingly subscribes or makes any false statement or report is guilty of a felony and upon conviction thereof shall be imprisoned in the state prison for a term of not less than 1 or more than 10 years or be fined an amount not to exceed $50,000, or both.

History: **En. Sec. 67, Ch. 89, L. 1927; re-en. Sec. 6014.71, R.C.M. 1935; amd. Sec. 15, Ch. 71, L. 1977; R.C.M. 1947, 5-707; amd. Sec. 7, Ch. 198, L. 1981.**

Cross-References

Selection of officers and employees — meetings and minutes, 32-1-325.
Fraud by director, officer, or employee, 32-1-464.
Penalty for receiving deposits when insolvent or for making false statements, 32-1-505.
Felony charges — suspension or prohibition, 32-1-908.

32-1-237 through 32-1-239 reserved.

32-1-240. Application to organize bank — rulemaking. (1) Any five or more individuals, at least three of whom are residents of the state, may file an application to incorporate a proposed bank. The application must be in the form and contain the information prescribed by the department by rule. A nonrefundable application fee, as set by the department by rule, must accompany the application.

(2) The information must be set forth in the application in sufficient detail to allow the commissioner to determine if the proposed new bank meets the requirements set forth in 32-1-242 and 32-1-244.

(3) The department shall adopt rules to implement 32-1-240 through 32-1-245.

History: **En. Sec. 1, Ch. 23, L. 2023.**

32-1-241. Authority to require additional investigatory information — fingerprinting. (1) The department may investigate any person named in the application or in other documents submitted for filing. The department may require the person to provide additional information for the department's further inquiry.

(2) For the purpose of further inquiry, the department may require any of the following individuals to submit fingerprints for submission to the federal bureau of investigation and any governmental agency or entity authorized to receive information for a state, national, and international criminal history background check:

(a) any individual required to be named in the application to organize; and

(b) any individual named in the proposed articles of incorporation of the bank or documents submitted for filing as a prospective incorporator, director, president, or officer of the bank.

History: **En. Sec. 2, Ch. 23, L. 2023.**

32-1-242. Department to review application. (1) The department shall ensure that sufficient information has been submitted to allow the commissioner to determine whether:

(a) the purposes of the proposed bank as stated in the proposed bank's business plan, articles of incorporation, and the application are consistent with the Bank Act;

(b) the character, financial responsibility, and general fitness of the owners and managers of the proposed bank command the confidence of the community in which the proposed bank is to be located and warrant the belief that the business of the proposed corporation will be honestly and efficiently conducted;

(c) the proposed directors and officers are competent to successfully manage a bank;

(d) there is a reasonable assurance of sufficient volume of business for the proposed bank to be economically viable;

(e) the suggested capitalization is adequate for the proposed banking institution's anticipated development and growth within a reasonable period of time;

(f) there is a reasonable public necessity and demand for a new bank at the proposed location or in the area in which the proposed new bank will operate;

(g) the corporate name assumed by the proposed bank, by reason of the use of any one or more of the words "bank", "banker", "banking", "trust", "savings", or "investment" in conjunction with any other word or words, resembles so closely the name of any other bank previously formed under this chapter as to be likely to cause confusion; and

(h) anything else is considered pertinent.

(2) The department may define the standards in subsection (1) by rule.

(3) The department may request additional information as needed to allow an assessment of the standards in 32-1-244 and this section.

(4) An applicant may withdraw an application at any time before the department determines the application is complete.

History: **En. Sec. 3, Ch. 23, L. 2023.**

32-1-243. Commissioner grants or denies application. (1) When the department determines an application to organize a new bank is complete, the department shall notify the applicant and submit the completed application to the commissioner for a decision.

(2) The commissioner shall review all the submitted materials and the results of the investigation and determine if a preponderance of the evidence shows the standards in 32-1-242 and 32-1-244 and the rules adopted pursuant to 32-1-242 and 32-1-244 have been met. The commissioner may further investigate the applicant, materials, application, and any other factors the commissioner considers relevant.

(3) If the commissioner approves the application, the commissioner shall determine the amount needed for initial capitalization of the institution based on the business plan and application of the proposed institution.

(4) The commissioner shall approve or deny the application within 60 days from receipt of the application unless the commissioner requests more information. If more information is requested, the commissioner shall act within 30 days of the date the additional information has been fully provided.

(5) The commissioner may grant conditional approval of an application and require the applicant to make additional showing or changes in the proposed bank as the commissioner considers advisable.

(6) The applicant may request a hearing on the decision of the commissioner as provided in Title 2, chapter 4, part 6, of the Montana Administrative Procedure Act.

History: **En. Sec. 4, Ch. 23, L. 2023.**

32-1-244. Grounds for refusing application to organize. The commissioner may disapprove an application on a finding that any person named in the application to organize or in other documents submitted for filing:

(1) is insolvent, either in the sense that the person's liabilities exceeded the person's assets or that the person cannot meet the person's obligations as they mature, or is in a financial condition in which the person cannot continue in business with safety to the person's customers;

(2) has engaged in dishonest, fraudulent, or illegal practices or conduct in any business or profession;

(3) has willfully or repeatedly violated or failed to comply with any provisions of the Bank Act or any rule or order of the commissioner;

(4) has been convicted of any felony or a misdemeanor, if an essential element of the crime is fraud or dishonesty;

(5) is not qualified to conduct a banking business on the basis of factors such as training, experience, and knowledge of the business;

(6) is permanently or temporarily enjoined by a court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of the banking business or other business that may lawfully be conducted by an insured institution;

(7) is the subject of an order of the commissioner subjecting the person to a civil penalty or removing the person from an office in any entity regulated by the commissioner; or

(8) is the subject of an order directing the person to cease and desist from any fraudulent or unlawful business or banking practice, subjecting the person to a civil penalty, or removing the person from an office in a financial institution or a consumer finance company issued by a state, the comptroller of the currency, the board of governors of the federal reserve system, or any other agency of the federal government or another state with regulatory authority over financial institutions or consumer finance companies.

History: En. Sec. 5, Ch. 23, L. 2023.

32-1-245. Additional requirements after approval of application. Following approval of the application, the incorporators must:

(1) file a signed original of the articles of incorporation with the department for filing with the secretary of state and pay the filing fee;

(2) provide acceptable proof that the capital of the institution has been placed into escrow;

(3) if the bank will accept money on deposit, prove that the bank has federal deposit insurance corporation insurance, or provide satisfactory assurance from the federal deposit insurance corporation that the proposed bank will be accepted for insurance when the applicants comply with certain stated minor requirements imposed by the federal deposit insurance corporation. "Minor requirements" must be of a type and character that the commissioner determines can be promptly complied with by the applicants without serious difficulty.

(4) provide proposed bylaws that comply with Montana law to the department for review and approval.

History: En. Sec. 6, Ch. 23, L. 2023.

32-1-246. Shell bank. The department shall adopt rules providing an application process, processing times, requirements, fees, and criteria for the approval of a shell bank.

History: En. Sec. 7, Ch. 23, L. 2023.

Part 3
Formation and Reorganization

Part Cross-References

Banks subject to corporate income tax, 15-31-101.

U.C.C. — investment securities, Title 30, ch. 8.

32-1-301. Organization and incorporation — articles of incorporation. (1) A person desiring to organize a banking corporation shall make and file articles of incorporation with the department and, on approval by the department, the department may file the articles with the secretary of state as provided in Title 35, chapter 14. The articles of incorporation must set forth:

(a) the information required by 35-14-202(1);

(b) the name of the city or town and county in which the principal office of the corporation is to be located;

(c) the names and places of residence of the initial shareholders and the number of shares subscribed by each;

(d) the number of the board of directors and the names of those initially agreed on; and

(e) the purpose for which the banking corporation is formed, which may be set forth by the use of the general terms defined in this chapter, with reference to each line of business in which the proposed corporation desires to engage.

(2) In addition to provisions required in subsection (1), the articles of incorporation may also contain provisions set forth in 35-14-202(2).

(3) A banking corporation may not adopt or use the name of any other banking corporation or association, and the corporation name must comply with 35-14-401(2) through (4).

(4) A banking corporation may not be organized or incorporated until the articles of incorporation have been submitted to and have been approved by the department and until it has obtained a certificate from the department authorizing the proposed corporation to transact the business specified in the articles of incorporation within this state.

(5) A banking corporation may not amend or restate its articles of incorporation until its articles of amendment or articles of restatement have been submitted to and have been approved by the department and until it has obtained approval from the department authorizing the proposed amendment or restatement.

(6) For banks organized before October 1, 1993, articles of agreement are considered articles of incorporation.

History: Ap. p. Sec. 6, Ch. 89, L. 1927; re-en. Sec. 6014.10, R.C.M. 1935; amd. Sec. 1, Ch. 7, L. 1965; Sec. 5-201, R.C.M. 1947; Ap. p. Sec. 2661, C. Civ. Proc. 1895; re-en. Sec. 7361, Rev. C. 1907; amd. Sec. 1, Ch. 39, L. 1921; re-en. Sec. 9964, R.C.M. 1921; re-en. Sec. 9964, R.C.M. 1935; amd. Sec. 21, Ch. 240, L. 1971; amd. Sec. 33, Ch. 94, L. 1973; amd. Sec. 59, Ch. 535, L. 1975; Sec. 93-100-2, R.C.M. 1947; R.C.M. 1947, 5-201, 93-100-2(part); amd. Sec. 1, Ch. 179, L. 1985; amd. Sec. 1, Ch. 278, L. 1989; amd. Sec. 14, Ch. 395, L. 1993; amd. Sec. 77, Ch. 382, L. 1997; amd. Sec. 13, Ch. 163, L. 2005; amd. Sec. 228, Ch. 271, L. 2019; amd. Sec. 15, Ch. 23, L. 2023; amd. Sec. 1, Ch. 415, L. 2023.

Cross-References

Taking acknowledgments and affidavits, 3-1-404.
Certificate of authenticity of Justice's Court's certificate of acknowledgment, 3-1-405.
Registration of assumed business name similar to reserved or registered name or mark prohibited, 30-13-202.
Number of persons necessary to form corporation, 32-1-104.
When advertising as bank prohibited — trade names restricted, 32-1-402.
Penalty for transacting business without certificate, 32-1-403.
Business corporations, Title 35, ch. 14.
Shareholder agreements, 35-9-301.

32-1-302. Incorporation. (1) The proposed articles of incorporation must be presented to the department, together with an application in writing in the form prescribed by the department, for a certificate authorizing the proposed corporation to transact the business specified in the articles of incorporation within this state.

(2) On the presentation of the proposed articles of incorporation, together with the application, the department shall ascertain whether the requisite capital of the bank, as required in 32-1-307, has been subscribed and been paid up in cash. The department shall also determine whether the corporation is being formed for any other purpose than the legitimate business contemplated by this chapter. The department shall determine whether the corporate name assumed by the bank, by reason of the use of any one or more of the words "bank", "banker", "banking", "trust", "savings", or "investment" in conjunction with any other word or words, resembles so closely the name of any other bank previously formed under this chapter as to be likely to cause confusion.

(3) The expenses of the department incurred in the examinations and investigations provided for in this chapter for the formation of new banks must be paid by the proposed bank through advance payment of a reasonable nonrefundable application fee that must be determined by the department by rule.

History: En. as part of Sec. 6, Ch. 89, L. 1927; re-en. Sec. 6014.10, R.C.M. 1935; amd. Sec. 2, Ch. 431, L. 1975; R.C.M. 1947, 5-202; amd. Sec. 1, Ch. 79, L. 1979; amd. Sec. 15, Ch. 395, L. 1993; amd. Sec. 16, Ch. 23, L. 2023.

Cross-References

Registration of assumed business name similar to reserved or registered name or mark prohibited, 30-13-202.
When advertising as bank prohibited — trade names restricted, 32-1-402.

32-1-303. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-202.1 by Sec. 3, Ch. 431, L. 1975; amd. Sec. 2, Ch. 71, L. 1977; R.C.M. 1947, 5-202.1.

32-1-304. Repealed. Sec. 2, Ch. 79, L. 1979.

History: En. Sec. 7, Ch. 89, L. 1927; re-en. Sec. 6014.11, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-205.

32-1-305. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. as part of Sec. 6, Ch. 89, L. 1927; re-en. Sec. 6014.10, R.C.M. 1935; amd. Sec. 4, Ch. 431, L. 1975; R.C.M. 1947, 5-203.

32-1-306. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. as part of Sec. 6, Ch. 89, L. 1927; re-en. Sec. 6014.10, R.C.M. 1935; R.C.M. 1947, 5-204.

32-1-307. Amount of capital. The commissioner shall determine the appropriate level of capitalization of the proposed corporation prior to the issuance of the certificate of authorization.

History: En. Sec. 8, Ch. 89, L. 1927; amd. Sec. 1, Ch. 81, L. 1935; re-en. Sec. 6014.12, R.C.M. 1935; amd. Sec. 1, Ch. 45, L. 1963; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-206; amd. Sec. 16, Ch. 395, L. 1993; amd. Sec. 17, Ch. 23, L. 2023.

32-1-308. Bylaws. The bylaws must be certified by a majority of the directors and the secretary of the corporation and recorded in the permanent records of the bank. Bylaws must be open to public inspection during office hours. A copy of the bylaws must also be transmitted to the department.

History: En. Sec. 13, Ch. 89, L. 1927; re-en. Sec. 6014.17, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-211; amd. Sec. 17, Ch. 395, L. 1993; amd. Sec. 15, Ch. 75, L. 2019.

Cross-References

Bylaws regarding banking hours and business days, 32-1-484.

32-1-309 through 32-1-320 reserved.

32-1-321. Calling of first meeting — cancellation of certificate. When the formation of the corporation is completed under the provisions of this chapter by the issuance of the certificate of incorporation by the secretary of state, any three such incorporators signing the articles of agreement may call the first meeting of the corporation at such time and place as they may appoint by giving notice thereof by publication in some newspaper of general circulation in the county in which the principal office for the transaction of business is to be located at least 5 days before the time appointed for such meeting. If all the subscribers to the capital stock unite in a call for such meeting, in writing, no notice is necessary. If the first meeting be not called within 30 days from the date of the certificate of incorporation or if such corporation shall fail to commence the business for which it is incorporated within 90 days from the date of the issuance of the certificate of authorization, the department is authorized to cancel such certificate of authorization.

History: En. Sec. 9, Ch. 89, L. 1927; re-en. Sec. 6014.13, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-207.

32-1-322. Board of directors — qualifications, tenure, and vacancies. (1) The affairs of the bank must be managed by a board of directors consisting of no fewer than three persons. At least two-thirds of the board must be residents of Montana. Directors need not be shareholders of the corporation unless required by the articles of incorporation or bylaws. A person who has been convicted of a crime against the banking laws of the United States or of any state may not be elected a director.

(2) (a) As set forth in the bylaws of the institution, the directors may serve a term of multiple years and the terms may be staggered.

(b) The annual meeting must be held before April 15 of each calendar year. If the election is not held on the day fixed for the annual meeting, the corporation is not dissolved, but an election may be held at any other time agreeable to the bylaws of the corporation, and the persons elected shall hold their office until successors are elected and qualified.

(c) Every director shall take and subscribe an oath that the director will diligently and honestly perform the director's duty in the office and that the director will not knowingly violate or permit a violation of any of the provisions of this chapter. The oaths must be made in duplicate. One copy must be transmitted to and filed with the department, and one copy must be kept on file in the office of the bank.

History: En. Sec. 10, Ch. 89, L. 1927; re-en. Sec. 6014.14, R.C.M. 1935; amd. Sec. 1, Ch. 78, L. 1957; amd. Sec. 5, Ch. 431, L. 1975; R.C.M. 1947, 5-208; amd. Sec. 1, Ch. 84, L. 1979; amd. Sec. 1, Ch. 341, L. 1981; amd. Sec. 1, Ch. 561, L. 1983; amd. Sec. 2, Ch. 179, L. 1985; amd. Sec. 1, Ch. 24, L. 1989; amd. Sec. 18, Ch. 395, L. 1993; amd. Sec. 2, Ch. 415, L. 2023.

Cross-References

Officers who may administer oaths, 1-6-101.

Persons previously convicted under banking laws — bank employment, 32-1-462.

32-1-323. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 23, Ch. 89, L. 1927; re-en. Sec. 6014.27, R.C.M. 1935; R.C.M. 1947, 5-502.

32-1-324. Repealed. Sec. 3, Ch. 24, L. 1989.

History: En. Sec. 11, Ch. 89, L. 1927; re-en. Sec. 6014.15, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-209; amd. Sec. 3, Ch. 179, L. 1985.

32-1-325. Selection of officers and employees — minutes of meetings. (1) The board of directors of a bank shall hold a meeting at least quarterly.

(2) The board of directors may elect a president, one or more vice-presidents, a cashier or treasurer, one or more assistant cashiers or treasurers, and other officers and employees that they may from time to time consider to be to the best interest of the bank and fix their compensation. The president must be chosen from the board of directors. Each bank shall file a list of the officers and directors of the bank with the department by July 31 of each year.

(3) The board of directors shall keep a correct report of the meetings of the board and of the stockholders. The minutes must disclose the dates of the meetings and the names of the directors or stockholders present. This record of the meetings of the board of directors must be signed, manually or electronically, by the presiding officer and the person responsible for preparing the minutes. The minutes must be read and approved at the following meeting of the board of directors, and the minutes of the following meeting must show that fact. The minutes must be available in the main office of the bank at all times and must be available to the department at the time of its examination of the books. A person who makes a material false entry in the record of the board meetings or who makes a material change or alteration of an entry made in the record is subject to removal pursuant to 32-1-468.

History: En. Sec. 12, Ch. 89, L. 1927; re-en. Sec. 6014.16, R.C.M. 1935; amd. Sec. 6, Ch. 431, L. 1975; R.C.M. 1947, 5-210; amd. Sec. 1, Ch. 264, L. 1983; amd. Sec. 4, Ch. 179, L. 1985; amd. Sec. 19, Ch. 395, L. 1993; amd. Sec. 16, Ch. 75, L. 2019; amd. Sec. 18, Ch. 23, L. 2023.

Cross-References

False statements and entries considered felony, 32-1-236.

Fraud by director, officer, or employee, 32-1-464.

Classification of offenses, 45-1-201.

Misdemeanor defined, 45-2-101.

32-1-326 through 32-1-330 reserved.

32-1-331. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 33, Ch. 89, L. 1927; re-en. Sec. 6014.37, R.C.M. 1935; R.C.M. 1947, 5-512.

32-1-332. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 22, Ch. 89, L. 1927; re-en. Sec. 6014.26, R.C.M. 1935; R.C.M. 1947, 5-501.

32-1-333. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. as part of Sec. 21, Ch. 89, L. 1927; amd. Sec. 1, Ch. 110, L. 1935; re-en. Sec. 6014.25, R.C.M. 1935; R.C.M. 1947, 5-401.

32-1-334. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 42, Ch. 89, L. 1927; re-en. Sec. 6014.46, R.C.M. 1935; R.C.M. 1947, 5-521.

32-1-335. Purchase or loan of own capital stock prohibited — exception. A bank may not purchase or invest its capital or surplus or money of its depositors, or any part of either, in shares of its own capital stock or loan its capital or surplus or the money of its depositors, or any part of either, on shares of its own capital stock unless the purchase or loan is necessary to prevent loss to the bank on debts previously contracted in good faith. However, a bank may redeem or otherwise purchase its own capital stock with the prior approval of the department and subject to any conditions that the department may require.

History: En. Sec. 36, Ch. 89, L. 1927; re-en. Sec. 6014.40, R.C.M. 1935; R.C.M. 1947, 5-515; amd. Sec. 2, Ch. 36, L. 2001; amd. Sec. 1, Ch. 105, L. 2003.

Cross-References

Restriction on investment in corporate stock, 32-1-422.

Purchase of obligation of bank by officer, 32-1-466.

32-1-336. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 1, Ch. 15, Ex. L. 1933; re-en. Sec. 6016.1, R.C.M. 1935; R.C.M. 1947, 5-1127.

32-1-337. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 2, Ch. 15, Ex. L. 1933; re-en. Sec. 6016.2, R.C.M. 1935; R.C.M. 1947, 5-1128.

32-1-338. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 3, Ch. 15, Ex. L. 1933; re-en. Sec. 6016.3, R.C.M. 1935; amd. Sec. 63, Ch. 431, L. 1975; R.C.M. 1947, 5-1129.

32-1-339. Right of examination by stockholder. A stockholder of a bank incorporated under the laws of this state who is not a director may not inspect the books and records of the bank showing its transactions with a customer. A stockholder may inspect the books and records of the bank as provided in Title 35, chapter 14, part 16.

History: En. Sec. 108, Ch. 89, L. 1927; re-en. Sec. 6014.119, R.C.M. 1935; R.C.M. 1947, 5-1035; amd. Sec. 20, Ch. 395, L. 1993; amd. Sec. 229, Ch. 271, L. 2019.

Cross-References

Examination and supervision by Department, 32-1-211.

32-1-340. Conversion of surplus and undivided profits to capital stock. (1) A bank having a surplus and undivided profits equal to or in excess of 50% of its capital stock may increase its capital stock by the issuance of new stock for a part of that surplus and undivided profits.

(2) The increase may be made by a vote of the stock, either at a regular annual stockholders' meeting or at a meeting called for that purpose in accordance with the bylaws of the corporation.

(3) All increases of capital stock made under this section must be accomplished in a manner conforming to the requirements of this chapter pertaining to surplus of banks when first incorporated.

(4) When a bank has voted to issue any stock as contemplated in this section, it shall certify that action to the department, which shall within 30 days approve or reject the plan. Departmental action is final, and written notice of the action must be given to the bank.

History: En. Sec. 97, Ch. 89, L. 1927; re-en. Sec. 6014.108, R.C.M. 1935; amd. Sec. 36, Ch. 431, L. 1975; R.C.M. 1947, 5-1024; amd. Sec. 21, Ch. 395, L. 1993.

Cross-References

Examination and supervision by Department, 32-1-211.
Dividends, surplus, losses, and bad debts, 32-1-452.
Calculation of profits, 32-1-453.

32-1-341 through 32-1-350 reserved.

32-1-351. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 14, Ch. 89, L. 1927; re-en. Sec. 6014.18, R.C.M. 1935; R.C.M. 1947, 5-212.

32-1-352. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 15, Ch. 89, L. 1927; re-en. Sec. 6014.19, R.C.M. 1935; R.C.M. 1947, 5-213.

32-1-353. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 16, Ch. 89, L. 1927; re-en. Sec. 6014.20, R.C.M. 1935; amd. Sec. 7, Ch. 431, L. 1975; R.C.M. 1947, 5-214.

32-1-354. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 17, Ch. 89, L. 1927; re-en. Sec. 6014.21, R.C.M. 1935; R.C.M. 1947, 5-215.

32-1-355. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 18, Ch. 89, L. 1927; re-en. Sec. 6014.22, R.C.M. 1935; amd. Sec. 8, Ch. 431, L. 1975; R.C.M. 1947, 5-216.

32-1-356. Repealed. Sec. 50, Ch. 395, L. 1993.

History: En. Sec. 19, Ch. 89, L. 1927; amd. Sec. 1, Ch. 145, L. 1931; re-en. Sec. 6014.23, R.C.M. 1935; amd. Sec. 1, Ch. 131, L. 1937; amd. Sec. 2, Ch. 7, L. 1965; amd. Sec. 9, Ch. 431, L. 1975; R.C.M. 1947, 5-217; amd. Sec. 5, Ch. 179, L. 1985.

32-1-357 through 32-1-360 reserved.

32-1-361. Change from state to national bank. (1) A bank may become a corporation for the purpose of carrying on the business of banking in this state, under the act of congress "to provide a national currency secured by a pledge of United States bonds and to provide for the circulation and redemption thereof", approved June 3, 1864, and under Title 52 of the Revised Statutes of the United States, when:

(a) stockholders owning two-thirds of the stock of the bank vote to become a national bank corporation or execute a written consent authorizing its directors to make the certificate required therefor by the laws of the United States; or

(b) a majority of the directors of the bank, authorized in their discretion to make the change, by a vote of the majority decide to become a national bank corporation.

(2) The cashier of the bank shall:

(a) publish notice of the change once a week for 4 consecutive weeks in the newspaper that the directors select;

(b) send a printed notice by mail or otherwise to all nonvoting or dissenting stockholders; and

(c) notify the department that the bank has decided to become a corporation under the laws of the United States.

History: En. Sec. 75, Ch. 89, L. 1927; re-en. Sec. 6014.86, R.C.M. 1935; amd. Sec. 32, Ch. 431, L. 1975; amd. Sec. 17, Ch. 71, L. 1977; R.C.M. 1947, 5-1002; amd. Sec. 22, Ch. 395, L. 1993.

32-1-362. National bank powers extended to state banks. (1) A bank organized under the laws of this state may engage in any activity or business in which the bank could engage if it were operating as a national bank if the power or activity is not expressly prohibited or limited by the laws of this state and:

(a) if the power or activity is clearly authorized to national banks by federal statute, regulations, or interpretive ruling issued or adopted by a federal banking regulator having jurisdiction over national banks; and

(b) upon application to and approval by the department.

(2) The department may adopt rules to govern the application procedure under this section. The department shall act upon an application under this section within 15 days of receipt of the application. The department may, for good cause, extend the time period for processing an application under this section for an additional 15 days. If the department fails to act on the application within 15 days of receipt of the application and does not extend the time period for good cause, the bank may engage in the activity requested without the approval of the department.

History: En. Sec. 1, Ch. 119, L. 1973; R.C.M. 1947, 5-1002.1; amd. Sec. 1, Ch. 163, L. 1981; amd. Sec. 8, Ch. 117, L. 1997; amd. Sec. 3, Ch. 100, L. 1999; amd. Sec. 3, Ch. 36, L. 2001.

Cross-References

Authority of state banks to make real estate loans, 32-1-430.
Authorized activities of credit unions, 32-3-206.

32-1-363. Surrender of charter by state bank. (1) Any bank which will become a corporation for carrying on the business of banking under the laws of the United States shall cease to be a corporation under the laws of this state, except that for the term of 3 years thereafter its corporate existence shall be deemed to continue for the purposes of prosecuting and defending suits by and against it and of enabling it to close its concerns and to dispose of and convey its property.

(2) The members of the board of directors last in office, when such corporation shall have become a corporation under the laws of the United States, shall continue to be the board of directors of the corporation, with power to take all necessary measures to carry out and perfect such organization by signing the articles of association and the organization certificate and adopting such regulations as may be just and proper and not inconsistent with the acts of congress in relation thereto.

(3) Such change from a state to a national bank corporation shall not release any such bank from its obligations to pay and discharge all the liabilities created by law or incurred by it before becoming a national bank corporation or any tax imposed by the laws of this state up to the date of its becoming such national bank corporation, in proportion to the time which has elapsed since the next preceding payment thereof.

History: En. Sec. 76, Ch. 89, L. 1927; re-en. Sec. 6014.87, R.C.M. 1935; R.C.M. 1947, 5-1003.

Cross-References

Corporate income tax — banks and savings and loan associations, Title 15, ch. 31, part 7.

32-1-364. Increase or reduction of capital stock. The directors of such new corporation may reduce the capital stock of the bank to its par value by dividing the surplus among its stockholders or may retain such portion of such surplus as they may deem necessary. In case of an increase of the capital stock under the provisions of the acts of congress, the directors may charge the shares of such increased capital stock with a like amount to place the whole of such capital stock on an equality and may award such new stock, or such proportion or fractional parts thereof, to such persons as they shall determine are entitled thereto and as are provided in their articles of association and the acts of congress. New directors may be chosen at such time and in the manner provided in the articles of association and the acts of congress.

History: En. Sec. 77, Ch. 89, L. 1927; re-en. Sec. 6014.88, R.C.M. 1935; R.C.M. 1947, 5-1004.

32-1-365. Certificate of change to national bank. (1) When any such bank has decided to become a corporation under the laws of the United States, the directors shall immediately thereafter execute and transmit to the comptroller of the currency the proper certificate and other instruments for its conversion into a national bank corporation under the laws of the United States.

(2) When any such bank shall have become authorized to commence the business of banking under the laws of the United States, all the property of such bank shall immediately, by act of law and without any conveyance or transfer, be vested in and become the property of the national bank corporation into which such bank shall have been converted.

History: En. Sec. 78, Ch. 89, L. 1927; re-en. Sec. 6014.89, R.C.M. 1935; R.C.M. 1947, 5-1005.

32-1-366 through 32-1-369 reserved.

32-1-370. Interstate merger of banks — interstate agreements. (1) A bank located in this state that has been in existence at least 5 years may enter into a merger transaction with a bank not located in this state. Prior approval of the department is required if any merger party is a bank organized under the laws of this state.

(2) Upon merger:

(a) each bank merger party merges into the resulting bank and the separate existence of every merger party except the resulting bank ceases;

(b) title to all real, personal, and mixed property owned by each merger party is vested in the resulting bank without reversion or impairment and without the necessity of any instrument of transfer;

(c) the resulting bank has all of the liabilities, duties, and obligations of each merger party, including obligations as fiduciary, personal representative, administrator, trustee, or guardian; and

(d) the resulting bank has all of the rights, powers, and privileges of each merger party, including appointment to the office of personal representative, administrator, trustee, or guardian under any will or other instrument made prior to the merger and in which a merger party was nominated to the office by the maker of the will or other instrument.

(3) Upon merger, a resulting bank that is organized under the laws of this state:

(a) shall designate and operate one of the prior main banking houses of the merger parties as its main banking house and may maintain and continue to operate the main banking houses of each of the other merger parties as a branch bank;

(b) may maintain the branch banks and other offices previously maintained by the merger parties; and

(c) may establish, acquire, or operate additional branch banks at any location where any bank that is a party to the merger could have established, acquired, or operated a branch bank under applicable federal or state law as if that bank had not been a party to the merger.

(4) A resulting bank organized under the laws of this state that intends to establish, acquire, or operate a branch bank under subsection (3)(c) must receive prior approval from the department as provided for in 32-1-372, whether or not the branch bank is to be located within or outside of this state.

(5) A resulting bank organized under federal law or the laws of another state shall simultaneously provide the department with copies of all applications or notices filed with any federal or other state regulatory agency, including applications seeking to establish, acquire, or operate additional branch banks within this state based on circumstances applicable to banks organized under the laws of this state included in subsection (3)(c).

(6) With respect to interstate banking authorized in subsection (1), the department may enter into agreements with other states establishing the division of supervisory responsibilities between the state in which a bank is organized and the state or states in which branch banks may be located.

(7) Upon merger, the resulting bank, including all depository institutions that are affiliates of the resulting bank, may not directly or indirectly control more than 30% of the total amount of deposits of insured depository institutions and credit unions located in this state.

History: En. Sec. 16, Ch. 117, L. 1997; amd. Sec. 2, Ch. 105, L. 2003; amd. Sec. 3, Ch. 49, L. 2013; amd. Sec. 17, Ch. 75, L. 2019.

32-1-371. Merger of banks. (1) (a) Any two or more banks doing business in this state may, with the approval of the department if any merger party is a bank organized under the laws of this state, merge into one bank, on terms and conditions lawfully agreed upon by a majority of the board of directors of each bank proposing to merge. Except as otherwise expressly provided in this chapter, a merger under this subsection (1) is governed by Title 35, chapter 1, if the resulting bank is organized under the laws of this state.

(b) A bank organized under the laws of this state may, with the approval of the department in the case of a resulting bank, merge with a savings association located in this state and may, upon the merger, maintain the branch banks and other offices previously maintained by both the bank and the savings association.

(2) Upon merger:

(a) each bank merger party merges into the resulting bank and the separate existence of every merger party except the resulting bank ceases;

(b) title to all real, personal, and mixed property owned by each merger party is vested in the resulting bank without reversion or impairment and without the necessity of any instrument of transfer;

(c) the resulting bank has all of the liabilities, duties, and obligations of each merger party, including obligations as fiduciary, personal representative, administrator, trustee, or guardian; and

(d) the resulting bank has all of the rights, powers, and privileges of each merger party, including appointment to the office of personal representative, administrator, trustee, or guardian under any will or other instrument made prior to the merger and in which a merger party was nominated to the office by the maker of the will or other instrument.

(3) Upon merger, the resulting bank shall designate and operate one of the prior main banking houses of the merging banks as its main banking house and the bank may maintain and continue to operate the main banking houses of each of the other merging banks as a branch bank.

(4) (a) Upon merger, the resulting bank may:

(i) maintain the branch banks and other offices previously maintained by the merging banks; and

(ii) establish, acquire, or operate additional branch banks at any location where any bank involved in the merger could have established, acquired, or operated a branch bank under applicable federal or state law if that bank had not been a party to the merger.

(b) A resulting bank organized under the laws of this state that intends to establish, acquire, or operate a branch bank under subsection (4)(a)(ii) must receive prior approval from the department as provided for in 32-1-372, whether or not the branch bank is to be located within or outside this state.

(c) A resulting bank organized under federal law or the laws of another state shall simultaneously provide the department with copies of all applications or notices filed with any federal or other state regulatory agency seeking to establish, acquire, or operate a branch bank under subsection (4)(a)(ii) within this state.

(5) Upon merger, the resulting bank, including all depository institutions that are affiliates of the resulting bank, may not directly or indirectly control more than 30% of the total amount of deposits of insured depository institutions and credit unions located in this state.

History: En. Sec. 94, Ch. 89, L. 1927; amd. Sec. 1, Ch. 108, L. 1931; re-en. Sec. 6014.105, R.C.M. 1935; amd. Sec. 171, Ch. 431, L. 1975; amd. Sec. 19, Ch. 71, L. 1977; R.C.M. 1947, 5-1021; amd. Sec. 4, Ch. 322, L. 1989; amd. Sec. 4, Ch. 265, L. 1995; amd. Sec. 9, Ch. 117, L. 1997; amd. Sec. 1, Ch. 15, L. 2005; amd. Sec. 4, Ch. 49, L. 2013; amd. Sec. 18, Ch. 75, L. 2019.

32-1-372. Branch bank. (1) A bank may establish and maintain branch banks, as provided in 32-1-371 and this section. The formation and operation of a branch bank in this state by a bank organized under the laws of this state require the prior approval of the department. A bank organized under the laws of this state may establish, acquire, or operate a branch bank or other office outside this state if approved by the department and if permitted by the laws of the jurisdiction where the branch bank or office is to be located.

(2) A branch bank may but is not required to offer all services and conduct all business authorized to be offered or conducted by the bank.

(3) A bank authorized to do banking business in this state may use a satellite terminal, as defined in 32-6-103, at any location permitted by the Montana Electronic Funds Transfer Act.

(4) A bank may continue to maintain and operate all branch banks and other banking offices in existence or authorized on July 1, 1997, without further consent, authorization, or approval of the department. All offices established and maintained by a bank, other than the main banking house, at which deposits are received, checks are paid, or money is lent must be considered branch banks for all purposes under this title.

(5) A bank located in this state may provide services for other banks located in this state, whether or not those banks are affiliates.

(6) With the prior approval of the appropriate federal regulator and state chartering authority, a bank that is not organized under the laws of this state may establish and operate a de novo branch in this state under the same terms that would apply to a bank organized under the laws of this state seeking approval from the department to establish and operate a de novo branch in this state.

(7) A bank that is not organized under the laws of this state that applies to the appropriate federal regulator and state chartering authority under subsection (6) to establish and operate a de novo interstate branch in Montana shall simultaneously file a copy of the application with the department for notification purposes.

(8) A bank shall notify the department and its customers of any branch bank closure or relocation.

(9) The department may adopt rules to implement this section.

History: En. Sec. 101, Ch. 89, L. 1927; re-en. Sec. 6014.112, R.C.M. 1935; amd. Sec. 1, Ch. 39, L. 1963; amd. Sec. 1, Ch. 80, L. 1965; amd. Sec. 170, Ch. 431, L. 1975; amd. Sec. 22, Ch. 503, L. 1977; R.C.M. 1947, 5-1028; amd. Sec. 5, Ch. 322, L. 1989; amd. Sec. 1, Ch. 15, L. 1991; amd. Sec. 5, Ch. 401, L. 1993; amd. Sec. 1, Ch. 307, L. 1995; amd. Sec. 10, Ch. 117, L. 1997; amd. Sec. 4, Ch. 36, L. 2001; amd. Sec. 2, Ch. 15, L. 2005; amd. Sec. 2, Ch. 49, L. 2011; amd. Sec. 19, Ch. 75, L. 2019; amd. Sec. 19, Ch. 23, L. 2023.

Cross-References

Montana Electronic Funds Transfer Act, Title 32, ch. 6, part 1.

32-1-373. Banks may join federal reserve bank. Any bank is hereby authorized and empowered to join or associate itself with the federal reserve bank, or any branch thereof, and nothing herein contained shall prevent or prohibit any bank from joining or associating itself with any such banks or branch thereof or from investing any part of its capital or surplus in the stock of such bank, in accordance with the terms and provisions of the act of congress creating such association. Any bank joining or associating itself with such bank shall be permitted to conform to and transact its business in accordance with the terms and provisions of the act of congress creating the same and the rules of such federal reserve bank.

History: En. Sec. 28, Ch. 89, L. 1927; re-en. Sec. 6014.32, R.C.M. 1935; R.C.M. 1947, 5-507.

Cross-References

Reserve requirements, 32-1-455.

32-1-374. Conversion of national bank to state bank. (1) A national bank may convert to a state bank on the consent in writing of the owners of two-thirds of the capital stock of the bank and with the approval of the department. The stockholders shall make, execute, and acknowledge articles of incorporation as required by the laws of the state of Montana and shall set forth in the articles of incorporation the written consent of the stockholders. When the articles and the department approval are filed as provided by law, the bank is converted under this chapter, and all assets, real and personal, of the national bank are vested in and become the property of the converted state bank, subject to all liabilities of the national bank not liquidated before the conversion.

(2) The cashier of the bank shall:

(a) publish notice of the change once a week for 4 consecutive weeks in the newspaper that the directors select;

(b) send a printed notice by mail or otherwise to all nonvoting or dissenting stockholders; and

(c) notify the department that the bank has decided to become a corporation under the laws of Montana.

History: En. Sec. 79, Ch. 89, L. 1927; re-en. Sec. 6014.90, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1006; amd. Sec. 23, Ch. 395, L. 1993; amd. Sec. 20, Ch. 75, L. 2019.

Cross-References

Examination and supervision by Department, 32-1-211.

32-1-375. Prohibition of acquisition — exception. (1) Notwithstanding any other provision of law, a bank holding company or any other company may not acquire or control an institution in this state that is an "insured bank" as defined in section 3(h) of the Federal Deposit Insurance Act (12 U.S.C. 1813(h)) or any institution eligible to become an insured bank as defined therein if the institution does not both accept demand deposits and engage in the business of making commercial loans.

(2) Nothing in this section prohibits the continued control of a financial institution eligible for insurance under the Federal Deposit Insurance Act by a company that acquired the financial institution prior to March 1, 1987.

History: En. Sec. 1, Ch. 491, L. 1987.

Cross-References

Demand deposits defined, 32-1-109.

Federal deposit insurance corporation, Title 32, ch. 1, part 6.

32-1-376. Sale of branch bank. Any bank may, with the approval of the department, buy from or sell to another bank, regardless of where either bank is located or doing business, all or substantially all of the business, assets, and liabilities of the selling bank's branch bank or branch banks that are physically located in this state.

History: En. Sec. 8, Ch. 265, L. 1995; amd. Sec. 11, Ch. 117, L. 1997; amd. Sec. 5, Ch. 49, L. 2013.

32-1-377. Agreement of purchase and sale. (1) The selling and purchasing banks shall enter into an agreement that must contain all the terms and conditions of the sale and that must contain:

(a) proper provision for the assumption, payment, transfer, or retention of all the liabilities of the selling bank as to the branch assets and business sold;

(b) proper provision for the assumption, payment, transfer, or retention of the purchasing bank of all fiduciary obligations of the branch or branch business sold.

(2) The agreement for purchase and sale of a state bank must be authorized and approved by the department. The agreement of purchase and sale of a national bank must be in accordance with the laws applicable to national banks.

History: En. Sec. 9, Ch. 265, L. 1995; amd. Sec. 12, Ch. 117, L. 1997.

32-1-378. Bank acquisition or control — notice or application — registration statement — violations — penalties. (1) A person may not acquire control of a bank until 30 days after filing with the department:

(a) a copy of the notice of change of control that is required to be filed with the federal banking regulatory agency; or

(b) a completed application as prescribed by the department in rule.

(2) The notice or application must be filed under oath and contain substantially all of the following information plus any additional information that the department may require as necessary or appropriate in the particular instance for the protection of bank depositors, borrowers, or shareholders and the public interest:

(a) the identity and banking and business experience of each person by whom or on whose behalf acquisition is to be made;

(b) the financial and managerial resources and future prospects of each person involved in the acquisition;

(c) the terms and conditions of any proposed acquisition and how the acquisition is to be made;

(d) the source and the amount of the funds or other consideration used or to be used in making the acquisition, and a description of the transaction and the names of the parties if any part of these funds or other consideration has been or is to be borrowed or otherwise obtained for making the acquisition;

(e) any plan or proposal that any person making the acquisition may have to liquidate the bank, to sell its assets, to merge it with any other bank, or to make any other major change in its business or corporate structure for management;

(f) the identification of any person employed, retained, or to be compensated by the acquiring party, or by any person on its behalf, who makes solicitations or recommendations to shareholders for the purpose of assisting in the acquisition and a brief description of the terms of the employment, retainer, or arrangement for compensation; and

(g) copies of all invitations for tenders or advertisements making a tender offer to shareholders for the purchase of their stock to be used in connection with the proposed acquisition.

(3) When a person, other than an individual or a corporation, is required to file an application under this section, the department may require that the information required by subsections (2)(a), (2)(b), and (2)(f) be provided for each person who has an interest in or controls a person filing an application as provided under this subsection.

(4) When a corporation is required to file an application under this section, the department may require that information required by subsections (2)(a), (2)(b), and (2)(f) be provided for the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of 25% or more of the outstanding voting securities of the corporation.

(5) If any tender offer, request or invitation for tenders, or other agreements to acquire control are proposed to be made by a registration statement under the Securities Act of 1933, 15 U.S.C. 77a, et seq., as amended, or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, 15 U.S.C. 78a, et seq., as amended, the registration statement or application may be filed with the department in lieu of the requirements of this section.

(6) An acquiring party shall also deliver a copy of any notice or application required by this section to the bank proposed to be acquired within 2 days after the notice or application is filed with the department.

(7) A bank or a bank holding company or a subsidiary of the bank or bank holding company may not acquire control of a bank located in this state if the bank, bank holding company, or subsidiary together with its affiliates would directly or indirectly control more than 30% of the total amount of deposits located in Montana of insured depository institutions and credit unions located in this state.

(8) The determination of the limit contained in subsection (7) must be based on public reports filed with the appropriate regulatory agency as of the December 31 preceding the submission to the appropriate federal banking regulatory agency of the application seeking prior approval of the acquisition of control of the bank.

(9) Any acquisition or change in control in violation of this section is void.

(10) Any person who willfully or intentionally violates this section or a rule adopted under this section is subject to a civil penalty of not more than $1,000 for each day the violation continues.

History: En. Sec. 3, Ch. 75, L. 2019.

32-1-379. Bank acquisition or control — disapproval by department — change of officers. (1) The department may disapprove the acquisition of a bank within 30 days after the filing of a complete application pursuant to 32-1-378.

(2) The department may have an extended period, not exceeding an additional 15 days from the period allowed in subsection (1), to disapprove the acquisition if:

(a) the poor financial condition of any acquiring party may jeopardize the financial stability of the bank or may prejudice the interests of the bank depositors, borrowers, or shareholders;

(b) the plan or proposal of the acquiring party to liquidate the bank, sell its assets, merge it with any person, or make any other major change in its business or corporate structure or management is not fair and reasonable to the bank's depositors, borrowers, or stockholders or is not in the public interest;

(c) the banking and business experience and the integrity of any acquiring party that would control the operation of the bank indicate that approval would not be in the interest of the bank's depositors, borrowers, or shareholders;

(d) the information provided by the application is insufficient for the department to make a determination;

(e) there has been insufficient time to verify the information provided and conduct an examination of the qualifications of the acquiring party; or

(f) the acquisition would not be in the public interest.

(3) An acquisition may be made before expiration of the disapproval period if the department issues written notice of intent not to disapprove the action.

(4) (a) The department shall set forth the basis for disapproval of any proposed acquisition in writing and shall provide a copy of the findings and order to the applicants and to the bank involved.

(b) The findings and order may not be disclosed to any other party and may not be subject to public disclosure under 32-1-234 unless either the findings, order, or both are appealed pursuant to the Montana Administrative Procedure Act.

(5) Whenever a change in control occurs, each party to the transaction shall notify the department within 10 business days of any changes or replacements of its chief executive officer or any director that occurs in the next 12-month period and provide a statement of the past and present business and professional affiliations of the new chief executive officer or director.

History: **En. Sec. 4, Ch. 75, L. 2019.**

32-1-380. Rulemaking. The department may adopt rules to implement 32-1-378 and 32-1-379.

History: **En. Sec. 5, Ch. 75, L. 2019.**

32-1-381. Repealed. Sec. 30, Ch. 75, L. 2019.

History: **En. Sec. 1, Ch. 401, L. 1993; amd. Sec. 5, Ch. 265, L. 1995; amd. Sec. 137, Ch. 42, L. 1997; amd. Sec. 3, Ch. 49, L. 2011; amd. Sec. 6, Ch. 49, L. 2013.**

32-1-382. Repealed. Sec. 14, Ch. 49, L. 2013.

History: **En. Sec. 2, Ch. 401, L. 1993; amd. Sec. 6, Ch. 265, L. 1995; amd. Sec. 5, Ch. 36, L. 2001; amd. Sec. 78, Ch. 483, L. 2001.**

32-1-383. Repealed. Sec. 30, Ch. 75, L. 2019.

History: **En. Sec. 3, Ch. 401, L. 1993; amd. Sec. 7, Ch. 265, L. 1995; amd. Sec. 13, Ch. 117, L. 1997; amd. Sec. 7, Ch. 49, L. 2013.**

32-1-384. Federal applications — comments. (1) A bank holding company shall file with the department a copy of applications submitted to a federal banking regulatory agency seeking prior approval of the proposed acquisition of a bank holding company located in this state. The acquiring bank holding company shall also file a statement verifying that the acquisition will not result in a violation of the limit in 32-1-378 (7).

(2) The applications and statement are public records, and the department shall allow public inspection of all nonconfidential portions of the applications and statements. The department shall solicit public comment on the applications by promptly publishing notice of the applications in a newspaper of general circulation in the county in which the bank holding company to be acquired is located. The department shall send the comments to the appropriate federal banking regulatory agency. The department may intervene in or take other action in a federal banking regulatory authority proceeding.

History: **En. Sec. 4, Ch. 401, L. 1993; amd. Sec. 14, Ch. 117, L. 1997; amd. Sec. 8, Ch. 49, L. 2013; amd. Sec. 21, Ch. 75, L. 2019.**

Part 4
Operation and Regulation

Part Cross-References

Home owners' loan corporation bonds — investment and security, 7-15-4504, 7-15-4505, 32-1-424, 72-31-102.
Deposit of state money in banks — interest, 17-6-102, 17-6-104, 17-6-105.
U.C.C. — negotiable instruments, Title 30, ch. 3.
U.C.C. — bank deposits and collections, Title 30, ch. 4.
U.C.C. — letters of credit, Title 30, ch. 5.
Warranty of money, 30-11-114.

Credit Transactions and Relationships, Title 31.
Issuing bad checks, 45-6-316.
Deceptive practices, 45-6-317.
Forgery, 45-6-325.
Discrimination by financial institutions prohibited, 49-2-305, 49-3-206.
Safe deposit box — joint tenancy, 70-1-308.
Banker's lien, 71-3-1502.
Delivery of money or personal property to minor under Uniform Probate Code, 72-5-104.
Montana Uniform Transfers to Minors Act, Title 72, ch. 26.

32-1-401. Bank advertising before issuance of charter. It shall be unlawful for any individual, firm, or corporation to advertise, publish, or otherwise promulgate that it is engaged in the banking business without first having obtained authority from the department, as herein provided. Any such individual or member of such firm or officer of any such corporation so offending shall be deemed guilty of a misdemeanor and upon conviction thereof shall be punished as provided by the laws of this state.

History: En. Sec. 107, Ch. 89, L. 1927; re-en. Sec. 6014.118, R.C.M. 1935; R.C.M. 1947, 5-1034.

Cross-References

Organization and incorporation — articles of incorporation — articles of agreement, 32-1-301.
Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.
Misdemeanor — when no penalty specified, 46-18-212.

32-1-402. When advertising as bank prohibited — trade names restricted. (1) Except as provided in subsection (3), a person, domestic or foreign, that is not subject to the supervision of the department and not required by the provisions of this chapter to report to it and that has not received a certificate to do a banking business from the department, may not:

(a) except for a student financial institution, as defined in 32-1-115, advertise that the person is receiving or accepting money or savings for deposit, investment, or otherwise and issuing notes or certificates of deposit; or

(b) advertise a sign at the place where the business is transacted having on it an artificial or corporate name or other words indicating that:

(i) the place or office is the place or office of a bank or trust company;
(ii) deposits are received there or payments made on checks; or
(iii) any other form of banking business is transacted there.

(2) The person, domestic or foreign, may not use any sign, logo, or marketing message, in any media, or use any written, printed, electronic, or internet-based instrument or material representation whatever directly or indirectly indicating that the business of the person is that of a bank, savings bank, or trust or investment company.

(3) (a) A Montana state-chartered bank or an out-of-state state-chartered bank that seeks to transact business under a name or title that contains the word "bank", "banker", "banking", "savings bank", "saving", "trust company", or "investment company" may do so only on the approval of the department. This section does not prohibit the use of the word "bank" in the name or title of any bank holding company registered with the board of governors of the federal reserve system pursuant to 12 U.S.C. 1844.

(b) The department may grant a waiver to allow the use of a restricted word listed in subsection (3)(a) to a nonprofit organization if:

(i) the organization is not acting as a financial institution; and
(ii) the name used is not likely to mislead a reasonable individual into thinking that the organization is acting as a financial institution.

(4) A person, domestic or foreign, violating a provision of this section shall forfeit to the state $100 a day for every day or part of a day during which the violation continues.

(5) On suit by the department, the court may issue an injunction restraining the person during pendency of the action and permanently from further using those words in violation of the provisions of this section or from further transacting business in a manner that leads the public to believe that its business is that of a bank, savings bank, or trust or investment company and may enter any other order or decree as equity and justice require.

History: Ap. p. Sec. 29, Ch. 89, L. 1927; re-en. Sec. 6014.33, R.C.M. 1935; amd. Sec. 14, Ch. 431, L. 1975; amd. Sec. 6, Ch. 71, L. 1977; Sec. 5-508, R.C.M. 1947; Ap. p. Sec. 1, Ch. 217, L. 1977; Sec. 5-508.1, R.C.M. 1947; R.C.M. 1947, 5-508, 5-508.1; amd. Sec. 24, Ch. 395, L. 1993; amd. Sec. 3, Ch. 105, L. 2003; amd. Sec. 4, Ch. 340, L. 2003; amd. Sec. 17, Ch. 123, L. 2013; amd. Sec. 20, Ch. 23, L. 2023.

Cross-References

Injunctions, Title 27, ch. 19.

Registration of assumed business name similar to reserved or registered name or mark prohibited, 30-13-202.

Organization and incorporation — articles of incorporation — articles of agreement, 32-1-301.

Incorporation, 32-1-302.

32-1-403. Penalty for transacting business without certificate. (1) A person, domestic or foreign, violating any provision of this section shall forfeit to the state $500 a day for every day or part of a day during which the violation continues.

(2) On action brought by the department, the court may issue an injunction restraining a person from further violating any provision of this section and may enter a further order or decree as equity and justice require.

(3) A person doing any of the things or transacting any of the business defined in Title 32, chapter 1, shall transact that business according to the provisions of the Bank Act, and the department may examine the accounts, books, papers, cash, and credits of that person, domestic or foreign, in order to ascertain whether that person has violated or is violating any provisions of this section.

History: En. Sec. 30, Ch. 89, L. 1927; re-en. Sec. 6014.34, R.C.M. 1935; amd. Sec. 15, Ch. 431, L. 1975; R.C.M. 1947, 5-509; amd. Sec. 1009, Ch. 56, L. 2009; amd. Sec. 21, Ch. 23, L. 2023.

Cross-References

Injunctions, Title 27, ch. 19.

Examination and supervision by Department, 32-1-211.

Organization and incorporation — articles of incorporation — articles of agreement, 32-1-301.

Incorporation, 32-1-302.

32-1-404 through 32-1-410 reserved.

32-1-411. Extent assets may be pledged. No bank, banker, or bank officer shall, except as otherwise authorized by law, pledge or hypothecate as collateral security for money borrowed its assets in a ratio exceeding 1½ times the amount borrowed (except as otherwise authorized by the department).

History: En. Sec. 99, Ch. 89, L. 1927; re-en. Sec. 6014.110, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1026.

Cross-References

Examination and supervision by Department, 32-1-211.

32-1-412. Limits on excessive borrowing. The department may prevent excessive borrowing by an institution that would have a significant effect on the institution's safety and soundness. If it appears to the department that an institution's borrowing is having a significant effect on the institution's safety and soundness, the department may require the institution to reduce its borrowing within a timeframe determined by the department.

History: (1)En. Sec. 110, Ch. 89, L. 1927; re-en. Sec. 6014.121, R.C.M. 1935; amd. Sec. 37, Ch. 431, L. 1975; Sec. 5-1037, R.C.M. 1947; (2)En. Sec. 54, Ch. 89, L. 1927; re-en. Sec. 6014.58, R.C.M. 1935; amd. Sec. 19, Ch. 431, L. 1975; Sec. 5-533, R.C.M. 1947; R.C.M. 1947, 5-533, 5-1037; amd. Sec. 25, Ch. 395, L. 1993; amd. Sec. 6, Ch. 36, L. 2001; amd. Sec. 4, Ch. 105, L. 2003.

Cross-References

Amount of capital, 32-1-307.

Credit unions — loan limit, 32-3-603.

32-1-413. Borrowing money for capital purposes — status of capital. Notwithstanding any other provision of law, any commercial bank, savings bank, trust company, or investment company, now in existence or which may be hereafter formed, shall have the power to borrow money for capital purposes upon such terms and conditions as may be approved by the department and for this purpose may issue capital notes or debentures therefor, such notes or debentures to be subordinate in right of payment to the payment in full of all deposits of such bank, savings bank, trust company, or investment company. The amount of money so borrowed shall be considered as capital for the purpose of determining the maximum amount of money that may be loaned by such bank, savings bank, trust company, or investment company to any person, partnership, or corporation and for the purpose of determining the maximum amount of money which such bank may borrow and for all other purposes of bank capital as may be required by law.

History: En. Sec. 1, Ch. 16, Ex. L. 1933; re-en. Sec. 6017.1, R.C.M. 1935; amd. Sec. 1, Ch. 11, L. 1967; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1130; amd. Sec. 16, Ch. 634, L. 1979.

Cross-References
Examination and supervision by Department, 32-1-211.
Amount of capital, 32-1-307.

32-1-414. No certificate of deposit to issue for borrowed money. No bank shall issue its certificate of deposit for the purpose of borrowing money or make partial payments upon any certificate of deposit.

History: En. Sec. 111, Ch. 89, L. 1927; re-en. Sec. 6014.122, R.C.M. 1935; R.C.M. 1947, 5-1038.

32-1-415 through 32-1-419 reserved.

32-1-420. Investment by trust fiduciary in management investment company or investment trust. (1) In the absence of an express prohibition in a trust instrument, a trust company fiduciary or the trust division of a financial institution, whether organized under state or federal law, may acquire and retain, invest, and reinvest fiduciary funds in the securities of or other interests in an open-end or closed-end management investment company or investment trust registered under 15 U.S.C. 80a-1 through 80a-64.

(2) The investments authorized in subsection (1) may be made even if the fiduciary or an affiliate of the fiduciary is providing services to a management investment company or investment trust and is receiving compensation as an investment adviser or manager, sponsor, broker, distributor, custodian, transfer agent, or registrar or for a similar service. The fiduciary shall disclose to all current income beneficiaries of the trust the rate, formula, and method of compensation for the services provided.

History: En. Sec. 1, Ch. 289, L. 1993.

Cross-References
Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31, part 1.

32-1-421. Investment of capital of savings banks. (1) The term "savings bank" as used in this section means any bank organized to do the business specified in 32-1-106.

(2) (a) At least one-half of the paid-in capital of a savings bank and one-half of the whole amount deposited in the savings bank must be invested in bonds or other securities of the United States or any of the states of the United States or any county, city, town, or school district of this state on which interest is regularly payable or federal land bank bonds or loaned on unencumbered real estate worth at least double the amount to be secured.

(b) The remainder may be invested in bonds or securities listed in subsection (2)(a) or in approved personal securities. However, a loan may not be made on personal securities of less than two responsible persons or collateral security to be approved by the directors, and a loan upon personal security may not be made to any person or partnership to an amount exceeding $10,000.

(c) Investments in United States government obligations permitted under subsection (2)(a) or (2)(b) may be made either directly or in the form of securities of or other interests in an open-end or closed-end management type investment company or investment trust registered under the Investment Company Act of 1940, 15 U.S.C. 80a-1 through 80a-64, if:

(i) the portfolio of the investment company or investment trust is limited to United States government obligations and repurchase agreements fully collateralized by United States government obligations; and

(ii) the investment company or investment trust takes delivery of the collateral for any repurchase agreement, either directly or through an authorized custodian.

(3) A president, vice president, director, or other officer or employee of a savings bank may not directly or indirectly borrow any of the funds of the bank or of its deposits or in any manner use the funds or deposits in the person's private affairs or business. A director may not receive any pay, salary, or emolument until the interest that the directors have determined to allow depositors has been provided for in accordance with the regulations of the corporation.

(4) The real estate that the corporation may lawfully purchase, hold, and convey is the real estate that is:

(a) necessary for the proper transaction of its business, not exceeding in value $50,000;

(b) mortgaged to it in good faith for money loaned pursuant to this chapter or given as security for money loaned or advanced;

(c) purchased at the sale on judgment or decree obtained or rendered on money loaned or advanced.

(5) Savings banks organized under the provisions of this chapter may not purchase, hold, or convey real estate in any other case or for any other purpose than is specified in subsection (4) and may not buy or sell any personal property, except personal property that may be necessary for the proper transaction of its business or that may have been pledged, mortgaged, or assigned to it to secure money loaned or advanced.

History: **En. Sec. 24, Ch. 89, L. 1927; re-en. Sec. 6014.28, R.C.M. 1935; R.C.M. 1947, 5-503; amd. Sec. 3, Ch. 137, L. 1989; amd. Sec. 1010, Ch. 56, L. 2009.**

Cross-References

County general obligation bonds, Title 7, ch. 7, part 22.
Municipal general obligation bonds, Title 7, ch. 7, part 42.
Investments authorized — certain government-guaranteed bonds, 7-15-4505.
Bond Validating Act, Title 17, ch. 5, part 2.
Economic development bonds — legal investments, 17-5-1525.
Municipal Finance Consolidation Act of 1983 bonds — legal investments, 17-5-1628.
School bonds, Title 20, ch. 9, part 4.
Contracts, Title 28, ch. 2, 3.
Mortgages of real property, Title 71, ch. 1, part 2.
Montana Facility Finance Authority bonds — legal investment, 90-7-113.

32-1-422. Restriction on investment in corporate stock — rulemaking authority. (1) Except as provided in subsections (2) and (3), a commercial or savings bank may not purchase or invest its capital or surplus or money of its depositors, or any part of its capital or surplus or money of its depositors, in the capital stock of any corporation unless the purchase or acquisition of capital stock is necessary to prevent loss to the bank on a debt previously contracted in good faith. Any capital stock purchased or acquired to prevent the loss must be sold by the bank within 6 months after purchase or acquisition if the capital stock can be sold for the amount of the claim of the bank against it. All capital stock purchased or acquired must be sold for the best price obtainable by the bank within 1 year after purchase or acquisition; however, if the stock is unmarketable, the stock must be charged off as an investment loss, which is equivalent to the stock's sale. A person or corporation violating any provision of this section shall forfeit to the state twice the nominal amount of the stock.

(2) A bank may acquire and hold for the bank's own account:

(a) up to 20% of the bank's capital and surplus in the capital stock of a bank service corporation organized solely for the purpose of providing services to banks;

(b) up to 20% of the bank's capital and surplus in the capital stock of a bankers' bank;

(c) shares of stock of a federal reserve bank and a federal home loan bank, without limitation of amount; and

(d) shares of stock or financial interests in an affiliate or a subsidiary, the business activities of which are limited to those allowed by law for a bank.

(3) A bank may invest any amount up to the limit established by the department of the bank's unimpaired capital and surplus in shares of stock of:

(a) the federal national mortgage association;

(b) the federal home loan mortgage corporation;

(c) the federal agricultural mortgage corporation; and

(d) other corporations created pursuant to acts of congress to meet the agricultural, housing, health, transit, educational, environmental, or similar needs of the nation when the department determines that the investment is in the public interest.

(4) A bank may, upon written application and approval of the department, make an investment in an amount permitted by the department by rule so long as the investment serves primarily to promote the public welfare, including the welfare of low- and moderate-income families and communities in need of jobs, housing, and public services. A bank may also, with the department's approval, purchase interests in an entity that makes investments for similar public welfare purposes.

(5) The department shall adopt rules to implement this section. The rules pertaining to the investments allowed in subsection (4) may be substantially equivalent to or more stringent than the eleventh power provided for in 12 U.S.C. 24 and the policy guidelines on community development issued by the office of the comptroller of the currency.

History: En. Sec. 39, Ch. 89, L. 1927; re-en. Sec. 6014.43, R.C.M. 1935; amd. Sec. 1, Ch. 115, L. 1973; R.C.M. 1947, 5-518; amd. Sec. 1, Ch. 259, L. 1983; amd. Sec. 3, Ch. 199, L. 1989; (4) En. Sec. 6, Ch. 199, L. 1989; amd. Sec. 26, Ch. 395, L. 1993; amd. Sec. 4, Ch. 100, L. 1999; amd. Sec. 1, Ch. 410, L. 1999; amd. Sec. 7, Ch. 36, L. 2001; amd. Sec. 1, Ch. 33, L. 2007; amd. Sec. 6, Ch. 9, L. 2011; amd. Sec. 22, Ch. 75, L. 2019; amd. Sec. 230, Ch. 271, L. 2019.

Cross-References

Rule defined, 2-4-102.

Adoption and publication of rules, Title 2, ch. 4, part 3.

U.C.C. — investment securities, Title 30, ch. 8.

Banks allowed to join federal reserve bank, 32-1-373.

32-1-423. Real estate that banks may purchase, hold, or convey. (1) (a) Except as provided in subsection (3), a bank organized under the provisions of this chapter may purchase, hold, or convey real estate that:

(i) is for its accommodation in the transaction of its business, but it may not invest an amount exceeding 100% of its paid-up capital and surplus in the lot and building in which the business of the company is or is projected to be carried on, furniture, equipment and fixtures, vaults and safety vaults, and boxes necessary or proper to carry on its banking business if property held for future use as a bank office site is held pursuant to a detailed written business plan formally adopted by the directors of the bank;

(ii) is mortgaged to it in good faith by way of security for loans previously made or money due to the bank;

(iii) is conveyed to it in satisfaction of debts previously contracted in the course of its business;

(iv) it purchases at sales under judgments, decrees, or mortgages held by the bank.

(b) The detailed written business plan required by subsection (1)(a)(i) must include information outlining the manner in which the acquired real estate will be developed for future use as a bank office site, including but not limited to the costs of projected construction, furniture, and equipment and fixtures. The plan must include sufficient information for the department to determine that the property will be used for a future bank office site.

(2) Real estate acquired in the manner set forth in subsections (1)(a)(iii) and (1)(a)(iv) may not be held longer than 5 years from the date of acquisition, unless special written permission is granted by the department. The real estate must be carried on the books of the bank for an amount not greater than its cost to the bank, including costs of foreclosure and other expenses of acquiring title.

(3) A bank organized under the provisions of this chapter may purchase, hold, or convey real estate that is residential and used for the exclusive purpose of providing housing accommodations for its employees. Residential real estate that is purchased, held, or conveyed as provided in this subsection is not subject to subsections (1) and (2).

History: En. Sec. 25, Ch. 89, L. 1927; re-en. Sec. 6014.29, R.C.M. 1935; amd. Sec. 12, Ch. 431, L. 1975; amd. Sec. 4, Ch. 71, L. 1977; R.C.M. 1947, 5-504; amd. Sec. 27, Ch. 395, L. 1993; amd. Sec. 15, Ch. 117, L. 1997; amd. Sec. 5, Ch. 105, L. 2003; amd. Sec. 1, Ch. 257, L. 2023.

Cross-References

Definitions and kinds of estates in real property, Title 70, ch. 15.

Mortgages, Title 71, ch. 1.

32-1-424. Investments of financial institutions. (1) Notwithstanding other provisions of the law, it is lawful for a bank, trust company, investment company or other financial institution operating under the laws of this state to invest the funds or money in its custody or possession, eligible for investment, in:

(a) debentures issued by the federal housing administrator and in obligations of national mortgage associations; and

(b) United States government obligations, either directly or in the form of securities of or other interests in an open-end or closed-end management type investment company or investment trust registered under the Investment Company Act of 1940 (15 U.S.C. 80a-1 through 80a-64), as amended, if:

(i) the portfolio of the investment company or investment trust is limited to United States government obligations and repurchase agreements fully collateralized by United States government obligations; and

(ii) the investment company or investment trust takes delivery of the collateral for any repurchase agreement, either directly or through an authorized custodian.

(2) The department shall publish a list of the permissible type of investments in United States government obligations as provided in subsection (1).

History: **(1), (2)En. Sec. 26, Ch. 89, L. 1927; re-en. Sec. 6014.30, R.C.M. 1935; Sec. 5-505, R.C.M. 1947; (3) En. Sec. 1, Ch. 5, Ex. L. 1933; amd. Sec. 1, Ch. 37, L. 1935; re-en. Sec. 5309.35, R.C.M. 1935; amd. Sec. 1, Ch. 24, L. 1937; Sec. 35-142, R.C.M. 1947; R.C.M. 1947, 5-505, 35-142(part); amd. Sec. 1, Ch. 36, L. 1979; amd. Sec. 4, Ch. 137, L. 1989; amd. Sec. 28, Ch. 395, L. 1993.**

Cross-References

Security for deposits of public funds, 17-6-103.
U.C.C. — investment securities, Title 30, ch. 8.
Credit unions — investment of funds, 32-3-701.
Mortgages, Title 71, ch. 1.

32-1-425. Definitions. For the purposes of 32-1-426 and 32-1-427, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Fiduciary" means a trustee under any trust, expressed, implied, resulting, or constructive; executor; administrator; guardian; committee; conservator; curator; tutor; custodian; nominee; receiver; trustee in bankruptcy; assignee for the benefit of creditors; partner; agent; officer of any corporation, public or private; public officer; or any other person acting in a fiduciary capacity for any person, trust, or estate.

(2) "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, two or more persons having a joint or common interest, or any other legal or commercial entity.

History: **En. 5-1601 by Sec. 3, Ch. 278, L. 1977; R.C.M. 1947, 5-1601; amd. Sec. 18, Ch. 123, L. 2013.**

Cross-References

Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31, part 1.
Trust Code, Title 72, ch. 38.

32-1-426. Deposit of securities in central depository. (1) Notwithstanding any other provision of law, any fiduciary, as defined in 32-1-425, holding securities in its fiduciary capacity, any bank or trust company holding securities as a custodian or managing agent, and any bank or trust company holding securities as custodian for a fiduciary is authorized to deposit or arrange for the deposit of the securities in a clearing corporation, as defined in 30-8-112. When the securities are deposited, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of the clearing corporation with any other securities deposited in the clearing corporation by any person regardless of the ownership of the securities, and certificates of small denomination may be merged into one or more certificates of larger denomination. The records of the fiduciary and the records of the bank or trust company acting as custodian, as managing agent, or a custodian for a fiduciary must show at all times the name of the party for whose account the securities are deposited. Title to the securities may be transferred by bookkeeping entry on the books of the clearing corporation without physical delivery of certificates representing the securities. A bank or trust company depositing securities pursuant to this section is subject to rules, which in the case of state-chartered institutions, the department and, in the case of national banking associations, the comptroller of the currency, may from time to time adopt. A bank or trust company acting as custodian for a fiduciary shall, on demand of the fiduciary, certify in writing to the fiduciary the securities deposited by the bank or trust company in the clearing corporation for the account of the fiduciary. A fiduciary shall, on demand by any party to a judicial proceeding for the settlement of the fiduciary's account or on demand by the attorney for the party, certify in writing to the party the securities deposited by the fiduciary in the clearing corporation for its account as the fiduciary.

(2) This section applies to any fiduciary holding securities in its fiduciary capacity and to any bank or trust company. holding securities as a custodian, managing agent, or custodian for a fiduciary regardless of the date of the agreement, instrument, or court order by which it is appointed and regardless of whether or not the fiduciary, custodian, managing agent, or custodian for a fiduciary owns capital stock of the clearing corporation.

History: **En. 5-1602 by Sec. 4, Ch. 278, L. 1977; R.C.M. 1947, 5-1602; amd. Sec. 87, Ch. 536, L. 1997; amd. Sec. 22, Ch. 23, L. 2023.**

Cross-References

U.C.C. — investment securities, Title 30, ch. 8.

Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31, part 1.

Trust administration, Title 72, ch. 38.

32-1-427. Fiduciaries — deposit of securities with federal reserve bank. (1) Notwithstanding any other provision of law, any bank or trust company when acting as fiduciary as defined in 32-1-425 and any bank or trust company when holding securities as custodian for a fiduciary is authorized to deposit or arrange for the deposit with the federal reserve bank in its district of any securities the principal and interest of which the United States or any department, agency, or instrumentality of the United States has agreed to pay or has guaranteed payment, to be credited to one or more accounts on the books of the federal reserve bank in the name of the bank or trust company, to be designated fiduciary or safekeeping accounts, to which accounts other similar securities may be credited. A bank or trust company depositing securities with a federal reserve bank must be subject to these rules with respect to the making and maintenance of the deposit as, in the case of state-chartered institutions, the department and, in the case of national banking associations, the comptroller of the currency may from time to time adopt. The records of the bank or trust company must at all times show the ownership of the securities held in the account. Ownership of and other interests in the securities credited to the account may be transferred by entries on the books of the federal reserve bank without physical delivery of any securities. A bank or trust company acting as custodian for a fiduciary shall, on demand of the fiduciary, certify in writing to the fiduciary the securities deposited by the bank or trust company with the federal reserve bank for the account of the fiduciary. A fiduciary shall, on demand by any party to its accounting or on demand by the attorney for the party, certify in writing to the party the securities deposited by the fiduciary with the federal reserve bank for its account as the fiduciary.

(2) This section must apply to all fiduciaries and custodians for fiduciaries acting on July 1, 1977, or who may act afterward regardless of the date of the instrument or court order by which they are appointed.

History: En. 5-1603 by Sec. 5, Ch. 278, L. 1977; R.C.M. 1947, 5-1603; amd. Sec. 23, Ch. 23, L. 2023.

Cross-References

U.C.C. — investment securities, Title 30, ch. 8.

Banks allowed to join federal reserve bank, 32-1-373.

Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31, part 1.

Trust administration, Title 72, ch. 38.

32-1-428 reserved.

32-1-429. Insurance activities — exemption — rulemaking. (1) A bank or a bank's subsidiary or affiliate may:

(a) except for title insurance, sell insurance of all types, including annuities, credit life insurance, and disability insurance; and

(b) act as an insurance producer, adjuster, consultant, or administrator as defined in Title 33, chapter 17.

(2) A bank or a bank's subsidiary or affiliate that engages in insurance activities authorized in subsection (1) is subject to the provisions of Title 33.

(3) A bank or bank's subsidiary or affiliate may, upon application to and approval by the department pursuant to 32-1-362, offer debt cancellation and suspension programs. Debt cancellation or suspension programs offered pursuant to this subsection are not insurance products subject to the provisions of Title 33. The department shall adopt rules to implement this subsection that must be substantially equivalent to or more stringent than federal laws, regulations, and regulatory guidelines that are applicable to debt cancellation or suspension programs offered by national banks.

History: En. Sec. 7, Ch. 100, L. 1999; amd. Sec. 1, Ch. 138, L. 2011.

32-1-430. Authority of state banks to make real estate loans — borrower insurance requirements. (1) A bank in this state has the same authority to make loans upon real estate that is given by acts of congress or the federal reserve system to national banks or bank members of the federal reserve system.

(2) A bank that is subject to this section may not require a borrower, as a condition of obtaining or maintaining a loan secured by real property, to provide insurance on improvements to real property in an amount that exceeds the reasonable replacement value of the improvements.

History: **En. Sec. 27, Ch. 89, L. 1927; re-en. Sec. 6014.31, R.C.M. 1935; amd. Sec. 1, Ch. 23, L. 1941; amd. Sec. 1, Ch. 90, L. 1945; amd. Sec. 1, Ch. 25, L. 1959; amd. Sec. 13, Ch. 431, L. 1975; amd. Sec. 5, Ch. 71, L. 1977; R.C.M. 1947, 5-506(part); amd. Sec. 1, Ch. 324, L. 2009.**

Cross-References

Loan of money — what constitutes, 31-1-101.
National bank powers extended to state banks, 32-1-362.
Certificate of change to national bank, 32-1-365.
Mortgages, Title 71, ch. 1.
Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31, part 1.

32-1-431. Repealed. Sec. 50, Ch. 395, L. 1993.

History: **En. Sec. 27, Ch. 89, L. 1927; re-en. Sec. 6014.31, R.C.M. 1935; amd. Sec. 1, Ch. 23, L. 1941; amd. Sec. 1, Ch. 90, L. 1945; amd. Sec. 1, Ch. 25, L. 1959; amd. Sec. 13, Ch. 431, L. 1975; amd. Sec. 5, Ch. 71, L. 1977; R.C.M. 1947, 5-506(part).**

32-1-432. Limitations on loans — rulemaking. (1) (a) The total loans or extensions of credit to a person, partnership, or corporation by a bank, including loans to a partnership and to the members of the partnership, may not exceed 20% of the amount of the unimpaired capital and surplus of that bank.

(b) The discount of bills of exchange drawn in good faith against actual existing values, the discount of bankers, acceptances of other banks, the discount of commercial or business paper actually owned by the person negotiating it and the obligations of the United States, general obligations of any state or of any political subdivision, or obligations issued under authority of the Federal Farm Loan Act may not be considered as money borrowed.

(c) The limitations imposed on total loans and extensions of credit by this section do not apply to loans and investments secured by obligations of the United States having a current market value of 100% of the amount loaned or invested.

(d) Loans or obligations are not subject under this section to any limitation based upon that unimpaired capital and surplus to the extent that they are secured or covered by guaranties, or by commitments or agreements to take over or to purchase them, made by a federal reserve bank or by the United States or a department, bureau, board, commission, or establishment of the United States, including a corporation wholly owned, directly or indirectly, by the United States.

(2) The combined liabilities of the members of a firm, partnership, or unincorporated association to the loaning bank must be included in the liabilities of the firm, partnership, or unincorporated association. The portion of the liabilities of the firm, partnership, or unincorporated association for which a member individually is legally responsible must be included in the liabilities of the member in determining the limitations imposed by this section. In determining the limitation for loans or extensions of credit to a limited partner of a limited partnership, the portions of the liabilities of the limited partnership for which the limited partner is free from liability must be excluded.

(3) When, in the judgment of the department, the liabilities of a corporation or the combined liabilities of a corporation and one or more of its stockholders to a bank are excessive, it shall require the reduction to the limits and within the time it prescribes.

(4) The limitations of this section do not apply to the extent that the loan or extension of credit is secured by pledged deposits in the lending bank.

(5) The limitations of this section do not apply to a loan of funds or an extension of credit made by a bank to another bank if the term of the loan or extension of credit does not exceed 2 business days.

(6) The limitations of this section do not apply to the extent that a loan is covered by a guaranty or by commitments or agreements to take over or purchase the loan made by an agency or board of the state of Montana authorized by law to provide the guaranties, commitments, or agreements.

(7) (a) A state-chartered bank may be exempted from the limitations of this section by applying to the department for a written waiver stipulating that the bank will be subject to the

limitations imposed on national banks under 12 U.S.C. 84 and the regulations of the office of the comptroller of the currency.

(b) A written waiver provided to a state-chartered bank in accordance with subsection (7)(a) may not be changed by the bank or revoked by the department for 2 years from the date of issue or for a different period determined by the department by rule.

(8) The department may adopt rules to carry out the purposes of this section, including rules differentiating between discretionary and nondiscretionary contractual commitments and rules specifying the types of derivative transactions in which a bank may engage and setting safety and soundness standards for engaging in derivative transactions.

(9) For purposes of this section, the terms "loan", "extension of credit", and "obligation" include:

(a) all direct or indirect advances of funds to a person on the basis of an obligation of the person to repay the funds;

(b) a liability of a state-chartered bank to advance funds to or on behalf of a person pursuant to a contractual commitment; and

(c) any credit exposure to a person arising from a derivative transaction, as defined in 12 U.S.C. 84(b)(3).

History: En. Sec. 44, Ch. 89, L. 1927; re-en. Sec. 6014.48, R.C.M. 1935; amd. Sec. 1, Ch. 71, L. 1943; amd. Sec. 1, Ch. 6, L. 1969; amd. Sec. 1, Ch. 118, L. 1973; amd. Sec. 17, Ch. 431, L. 1975; R.C.M. 1947, 5-523; amd. Sec. 1, Ch. 258, L. 1983; amd. Sec. 1, Ch. 315, L. 1985; amd. Sec. 29, Ch. 395, L. 1993; amd. Sec. 5, Ch. 100, L. 1999; amd. Sec. 1, Ch. 121, L. 2013.

Cross-References

Guaranty, Title 28, ch. 11, parts 1 and 2.
Loan of money — what constitutes, 31-1-101.

32-1-433. Investment in certain securities — rulemaking authority. (1) A bank may purchase, sell, underwrite, and hold investment securities that are obligations in the form of bonds, notes, or debentures, as provided in rules adopted by the department. In addition, unless limited by the department by rule, a bank may purchase, sell, underwrite, and hold those investment securities that are derivative transactions that national banks are expressly authorized to purchase, sell, underwrite, and hold. A bank may hold without limit investment securities that are general obligations of the United States, obligations that are guaranteed fully as to principal and interest by the United States, or general obligations of any state.

(2) The department shall adopt rules to implement this section.

History: En. Sec. 38, Ch. 89, L. 1927; re-en. Sec. 6014.42, R.C.M. 1935; amd. Sec. 7, Ch. 71, L. 1977; R.C.M. 1947, 5-517; amd. Sec. 1, Ch. 535, L. 1983; amd. Sec. 4, Ch. 199, L. 1989; (2) En. Sec. 6, Ch. 199, L. 1989; amd. Sec. 2, Ch. 121, L. 2013.

Cross-References

Rule defined, 2-4-102.
Adoption and publication of rules, Title 2. ch. 4, part 3.
County general obligation bonds, Title 7, ch. 7, part 22.
Municipal general obligation bonds, Title 7, ch. 7, part 42.
Bond Validating Act, Title 17, ch. 5, part 2.
Economic development bonds — procedure prior to financing projects, 17-5-1526.
Economic development bonds — procedure prior to financing major projects, 17-5-1527.
School bonds, Title 20, ch. 9, part 4.
Montana Agricultural Loan Authority Act — loan agreements, 80-12-201.

32-1-434. Financial institutions authorized to obtain insurance and make loans when approved by federal housing administrator. Notwithstanding any other provisions of the law of this state restricting the amount of any loan in relation to the value of the real estate and/or restricting the term of any such loan and/or restricting the rate of interest on any such loan, it shall be lawful for any corporation, bank, trust company, insurance company, investment company, and any other financial institution which has been approved as a mortgagee by the federal housing administrator to obtain insurance and to make such loans secured by real estate as the federal housing administrator insures or makes a commitment to insure.

History: En. Sec. 1, Ch. 8, L. 1935; re-en. Sec. 6018.1, R.C.M. 1935; amd. Sec. 1, Ch. 25, L. 1937; R.C.M. 1947, 5-1131.

Cross-References

Insurance on deposits of public funds, 17-6-102.

32-1-435. Federal housing securities eligible collateral. Wherever collateral must or may be furnished by any depository in the state of Montana as security for the deposit of any funds whatsoever or wherever collateral must or may be deposited with any official of the state of Montana pursuant to any statute of this state, mortgages insured and debentures issued by the federal housing administrator shall be considered eligible collateral for such purposes.

History: En. Sec. 2, Ch. 25, L. 1937; R.C.M. 1947, 5-1132.

Cross-References

Security for deposits of public funds, 17-6-103.

32-1-436. Repealed. Sec. 2, Ch. 9, L. 1983.

History: En. Sec. 48, Ch. 89, L. 1927; re-en. Sec. 6014.52, R.C.M. 1935; amd. Sec. 1, Ch. 239, L. 1969; amd. Sec. 1, Ch. 196, L. 1975; R.C.M. 1947, 5-527.

32-1-437. Acceptance and issuance of drafts — rulemaking authority. (1) A bank organized and existing under the laws of Montana may accept for payment at a future date drafts drawn upon it by its customers authorizing the holders of the drafts to draw drafts upon it or its correspondents at sight or on time if the total amount of drafts accepted for any one person, firm, or corporation does not at any one time exceed 20% of the capital and surplus of the accepting or issuing bank.

(2) The department may adopt rules to implement this section.

History: En. Sec. 74, Ch. 89, L. 1927; re-en. Sec. 6014.85, R.C.M. 1935; amd. Sec. 11-103, Ch. 264, L. 1963; R.C.M. 1947, 5-1001; amd. Sec. 5, Ch. 199, L. 1989; (2) En. Sec. 6, Ch. 199, L. 1989; amd. Sec. 10, Ch. 265, L. 1995.

Cross-References

Rule defined, 2-4-102.
Adoption and publication of rules, Title 2, ch. 4, part 3.
U.C.C. — bank deposits and collections, Title 30, ch. 4.

32-1-438 and 32-1-439 reserved.

32-1-440. Financial institution's responsibility to provide notice when funds become available for withdrawal. (1) A depository bank shall provide clear and conspicuous written notice of the time periods and exceptions to the periods concerning when funds become available for withdrawal as of right on deposit by check or similar instrument in the customer's deposit account. The notice must state the cutoff hour, if any, fixed by the financial institution after which an item is treated as being received at the opening of the next business day.

(2) This notice must be:

(a) provided to a potential customer prior to opening a deposit account; and

(b) posted in a conspicuous manner at each financial institution, automated teller machine location, or other device that accepts deposits.

(3) A deposit slip, envelope, or any other printed form furnished by the depository financial institution for use in connection with deposits must contain the following notice, printed in a conspicuous manner: "Your deposit may not be available for immediate withdrawal. Consult posted notices for further information."

History: En. Sec. 1, Ch. 491, L. 1985; amd. Sec. 67, Ch. 51, L. 1999.

Cross-References

Bank, 30-1-201.
Customer, 30-4-104.
Item, 30-4-104.
U.C.C. — depositary bank defined, 30-4-105.
When certain credits become available for withdrawal, 30-4-213.

32-1-441. Certified checks. (1) Whenever a check drawn on any bank is certified by any officer or employee of such bank, the amount thereof shall be immediately charged against the account of the person, firm, or corporation drawing the same.

(2) It shall be unlawful for any officer or employee of any bank to certify any check drawn upon such bank, unless at the time such check is certified the person, firm, or corporation drawing the check has on deposit with the bank an amount of money subject to the payment of such check equal to the amount specified in such check.

(3) Any officer or employee of any bank who shall willfully violate the provisions of this section or shall resort to any device or receive any fictitious obligation, directly or indirectly, in order to evade the provisions hereof shall be guilty of felony.

History: **En. Sec. 47, Ch. 89, L. 1927; re-en. Sec. 6014.51, R.C.M. 1935; amd. Sec. 1, Ch. 9, L. 1947; R.C.M. 1947, 5-526.**

Cross-References

False statements and entries considered felony, 32-1-236.
Felony charges — suspension or prohibition, 32-1-908.
Classification of offenses, 45-1-201.
Felony defined, 45-2-101.
Felony — when no penalty specified, 46-18-213.

32-1-442. Repealed. Sec. 134, Ch. 494, L. 1993.

History: **En. Sec. 49, Ch. 89, L. 1927; re-en. Sec. 6014.53, R.C.M. 1935; amd. Sec. 1, Ch. 91, L. 1967; R.C.M. 1947, 5-528.**

32-1-443. Repealed. Sec. 134, Ch. 494, L. 1993.

History: **En. Sec. 50, Ch. 89, L. 1927; re-en. Sec. 6014.54, R.C.M. 1935; R.C.M. 1947, 5-529.**

32-1-444. Deposit in name of minor. Whenever any deposit shall be made in any bank by or in the name of any minor, the same shall be held for the exclusive right and benefit of such minor and free from the control or lien of all persons whatsoever, except creditors, and shall be paid, with any interest due thereon, to the person in whose name the deposit was made, and the receipt of such minor is a sufficient release or discharge for such deposit to the bank.

History: **En. Sec. 51, Ch. 89, L. 1927; re-en. Sec. 6014.55, R.C.M. 1935; amd. Sec. 9, Ch. 71, L. 1977; R.C.M. 1947, 5-530.**

Cross-References

Parental control over property of child, 40-6-232.
Periods of minority — how calculated, 41-1-102.
Minor cannot disaffirm certain obligations, 41-1-306.
Montana Uniform Transfers to Minors Act, Title 72, ch. 26.

32-1-445. Demand or time deposits. Demand deposits, within the meaning of this chapter, shall comprise all deposits payable within 7 days, and time deposits shall comprise all deposits payable after 7 days and all savings accounts and certificates of deposit which are subject to not less than 7 days' notice before payment.

History: **En. Sec. 52, Ch. 89, L. 1927; re-en. Sec. 6014.56, R.C.M. 1935; R.C.M. 1947, 5-531; amd. Sec. 1, Ch. 75, L. 1985.**

Cross-References

Demand deposits defined, 32-1-109.
Time deposits defined, 32-1-109.

32-1-446. Safe deposit department. A bank may conduct a safe deposit department. The liability of any bank for the safekeeping and protection of the contents of safety deposit boxes is determined by the contract endorsed on the receipt delivered to the renter of a box at the time of the rental. However, the obligation of the bank is limited to the exercise of ordinary diligence and care to protect the contents of the box from loss or damage by fire, theft, or other causes.

History: **En. Sec. 35, Ch. 89, L. 1927; re-en. Sec. 6014.39, R.C.M. 1935; R.C.M. 1947, 5-514; amd. Sec. 30, Ch. 395, L. 1993; amd. Sec. 78, Ch. 382, L. 1997; amd. Sec. 14, Ch. 163, L. 2005.**

Cross-References

Safe deposit box — joint tenancy, 70-1-308.

32-1-447. Giving security for deposit prohibited — exceptions. It is unlawful for any bank to pledge, mortgage, or hypothecate to any depositor any of its real or personal property as security for any deposit, and any pledge, mortgage, or hypothecation made in violation thereof is unenforceable. This provision does not apply to any deposits of money of the United States, public funds deposited in accordance with the provisions of any depository act of this state or the United States, or bankruptcy estate funds or deposits, including deposits of receivers or trustees in bankruptcy, deposited under the direction and supervision of a court of record of the state of Montana or of the United States.

History: **En. Sec. 112, Ch. 89, L. 1927; re-en. Sec. 6014.123, R.C.M. 1935; amd. Sec. 1, Ch. 33, L. 1941; amd. Sec. 22, Ch. 71, L. 1977; R.C.M. 1947, 5-1039.**

Cross-References

Investment of public funds, Art. VIII, sec. 13, Mont. Const.
Security for deposits of public funds, 17-6-103.
Receivers — investment of funds, 27-20-303.
Claims — order of payment — priorities, 32-1-534.

32-1-448. Payments to foreign administrator. Any bank doing business in this state may pay any money remaining to the credit of a deceased depositor or deliver any personal property in its possession belonging to such deceased depositor to an administrator or executor of such depositor duly appointed and qualified in another state, provided no demand therefor shall have been previously made by an administrator or executor appointed in any county of this state, and such payment shall discharge the bank making the same from its liability on account of such deposit.

History: **En. Sec. 104, Ch. 89, L. 1927; re-en. Sec. 6014.115, R.C.M. 1935; R.C.M. 1947, 5-1031.**

Cross-References

Payment of debt and delivery of property to foreign representative, 72-4-306.

32-1-449 and 32-1-450 reserved.

32-1-451. Statement of capital, resources, and liabilities. A bank or officer of a bank may not advertise in any manner or publish any statement of the capital authorized or subscribed unless the bank or officer advertises and publishes in connection with the advertisement the amount of capital actually paid up. A bank may not publish a statement of its resources or liabilities in connection with those of any other bank unless the statement shows the resources and liabilities of each bank separately.

History: **En. Sec. 32, Ch. 89, L. 1927; re-en. Sec. 6014.36, R.C.M. 1935; R.C.M. 1947, 5-511; amd. Sec. 1011, Ch. 56, L. 2009.**

Cross-References

Amount of capital, 32-1-307.

32-1-452. Dividends, surplus, losses, and bad debts. (1) The directors of a bank may, at certain times and in the manner as the bank's bylaws prescribe, declare, and pay dividends to the stockholders of so much of the net undivided profits of the bank as may be appropriated for that purpose, but every bank shall, before declaring any dividend, carry at least 25% of the bank's net earnings for the period covered by the dividend to the bank's surplus, until the surplus is 50% of the bank's paid-up capital stock. The whole or any part of the surplus may at any time be converted into paid-in capital, but the surplus must be restored as provided in this subsection until the surplus amounts to 50% of the aggregate paid-up capital stock. A larger surplus may be created.

(2) A bank must receive prior approval from the department to pay a dividend if:

(a) the bank is rated lower than a 1 or a 2 using the uniform financial institutions rating system adopted by the federal financial institutions examination council; or

(b) the dividend would reduce the tier 1 leverage ratio below 8%, or the bank has a tier 1 leverage ratio below 8% when the dividend is declared.

(3) The department may require a bank to suspend the payment of any or all dividends until all requirements imposed in writing on the bank by the department have been met.

(4) Losses sustained by a bank in excess of the bank's undivided profits may be charged to and paid from the surplus, but the surplus must be restored in the manner provided in subsection (1) in the amount required by this chapter.

History: **En. Sec. 34, Ch. 89, L. 1927; re-en. Sec. 6014.38, R.C.M. 1935; R.C.M. 1947, 5-513; amd. Sec. 31, Ch. 395, L. 1993; amd. Sec. 23, Ch. 75, L. 2019; amd. Sec. 24, Ch. 23, L. 2023.**

Cross-References

Report of declaration of dividend, 32-1-232.

Conversion of surplus and undivided profits to capital stock, 32-1-340.

32-1-453. Calculation of profits. Interest or commissions unpaid, although due or accrued, on debts owing to any bank may not be included in calculation of its profits, unless the bank keeps its books on a complete accrual basis in which event the bank shall show on its books accrued interest receivable on notes, bonds, and other investments, unless the same is past due, and shall also carry on its books accrued interest, taxes, and expenses payable.

History: **En. Sec. 46, Ch. 89, L. 1927; amd. Sec. 1, Ch. 64, L. 1931; re-en. Sec. 6014.50, R.C.M. 1935; R.C.M. 1947, 5-525; amd. Sec. 138, Ch. 42, L. 1997.**

Cross-References

Conversion of surplus and undivided profits to capital stock, 32-1-340.

32-1-454. Past-due and doubtful paper. Every bank carrying any bad debt or a debt of doubtful value as an asset shall upon the request or demand of the department collect the same or put it in good bankable condition or charge it out of its books.

History: En. Sec. 102, Ch. 89, L. 1927; re-en. Sec. 6014.113, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1029.

Cross-References

U.C.C. — negotiable instruments, Title 30, ch. 3.

32-1-455. Reserve requirements. (1) A bank, except a reserve bank, shall maintain at all times a reserve of that percentage of its deposit liabilities as required by the appropriate federal regulator.

(2) The department may establish reserve requirements if the federal regulator discontinues reserve requirements.

(3) A bank approved by the department as a reserve bank shall maintain at all times a reserve as the department requires by rule.

(4) A solvent bank of good repute having a full paid-up capital and surplus as the department requires by rule and doing business in this state or any other state may be designated by the department as a reserve agent for Montana banking institutions. The approval or designation may be withdrawn or withheld at any time by the department for cause.

(5) A bank whose reserve drops below the legal requirements shall report the matter to the department immediately and as often as the department asks for a report.

(6) When the reserve of a bank falls below the legal requirements, the bank may not increase its loans or discounts except by discounting or purchasing bills of exchange payable at sight or on demand, and the department shall notify a bank whose reserve may be below the amount required to make good the reserve.

(7) In arriving at deposit liabilities with regard to bank deposits, the net balance of amounts due to and from other banks must be used as the basis for ascertaining the deposit liability to banks against which reserves are carried.

(8) Compliance by member banks with the federal reserve banking laws, rules, and regulations is compliance with the reserve requirements and conditions of this chapter and entitles those federal reserve member banks to the rights and privileges accruing from compliance with this chapter.

History: (1) thru (4), (6) thru (8)En. Sec. 53, Ch. 89, L. 1927; re-en. Sec. 6014.57, R.C.M. 1935; amd. Sec. 1, Ch. 6, L. 1967; amd. Sec. 18, Ch. 431, L. 1975; Sec. 5-532, R.C.M. 1947; (5)En. Sec. 103, Ch. 89, L. 1927; re-en. Sec. 6014.114, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; Sec. 5-1030, R.C.M. 1947; R.C.M. 1947, 5-532, 5-1030; amd. Sec. 32, Ch. 395, L. 1993.

Cross-References

Examination and supervision by department, 32-1-211.
Banks allowed to join federal reserve bank, 32-1-373.

32-1-456 through 32-1-460 reserved.

32-1-461. Bonding of employees. (1) The board of directors of a bank shall require bonding for all officers and employees of the bank whose duty includes the handling of money, notes, bonds, credits, and cash items and whose duties include bookkeeping or the making of entries in relation to the business of the bank and its customers.

(2) The board of directors shall by order entered upon the minute books of the board designate the officers and employees to be bonded and the amount of bonds to be given. Action as to the personnel, the amount of bonds, and the surety company or sureties is subject to approval by the department, and the bonds must be in a form provided or approved by the department.

(3) The bonds must be approved by the president of the bank, and the president's or executive officer's action must be reported to the board of directors.

(4) All bonds required by this section must be kept in the custody of the bank subject to inspection by examiners from the department. However, as far as possible, they may not be placed in the custody of the officer or employee for whom the bond is given.

History: En. Sec. 105, Ch. 89, L. 1927; amd. Sec. 3, Ch. 145, L. 1931; re-en. Sec. 6014.116, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; amd. Sec. 21, Ch. 71, L. 1977; R.C.M. 1947, 5-1032; amd. Sec. 79, Ch. 382, L. 1997; amd. Sec. 15, Ch. 163, L. 2005.

Cross-References

Suretyship, Title 28, ch. 11, part 4.
Examination and supervision by Department, 32-1-211.
Selection of officers and employees — meetings and minutes, 32-1-325.

32-1-462. Persons previously convicted under banking laws — bank employment. It is unlawful for a person who has been convicted of a violation of the banking laws of any state or nation to accept employment in a bank in this state without first stating the relevant facts to the directors of the bank. A person who has been convicted of a banking law violation may not be employed in a bank without the approval of the department, granted in writing after a full consideration of the facts.

History: En. Sec. 120, Ch. 89, L. 1927; re-en. Sec. 6014.130, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1046; amd. Sec. 80, Ch. 382, L. 1997; amd. Sec. 16, Ch. 163, L. 2005.

Cross-References

Criminal justice policy — rights of convicted, Art. II, sec. 28, Mont. Const.
Examination and supervision by Department, 32-1-211.
Board of directors — qualifications, tenure, and vacancies, 32-1-322.
Selection of officers and employees — meetings and minutes, 32-1-325.
Violation of notice or final order — penalties, 32-1-921.

32-1-463. Sale of securities by officer to bank. (1) A director, officer, employee, or controlling stockholder of any bank may not, directly or indirectly, for the person's account, for the person, or as the partner or agent of others sell or transfer or cause to be sold or transferred to the bank of which the person is a director, officer, employee, or controlling stockholder any note or bond secured by any mortgage or trust deed on real estate or any contract arising from the sale of real estate, in which the director, officer, employee, or controlling stockholder is personally or financially interested, without a vote of the majority of the board of the bank, duly noted upon the minutes of the meeting at which the transaction is decided upon. The minutes must be signed by a majority of the board.

(2) Any director, officer, employee, or controlling stockholder of any bank who knowingly violates or consents to the violation of this provision is guilty of a felony.

History: En. Sec. 37, Ch. 89, L. 1927; re-en. Sec. 6014.41, R.C.M. 1935; R.C.M. 1947, 5-516; amd. Sec. 1012, Ch. 56, L. 2009.

Cross-References

Selection of officers and employees — meetings and minutes, 32-1-325.
Felony charges — suspension or prohibition, 32-1-908.

32-1-464. Fraud by director, officer, agent, or employee. A director, executive officer, agent, or employee of a bank is guilty of a felony if that person:

(1) knowingly receives or takes possession of any bank property, except in payment for a just demand, and with intent to defraud:

(a) fails to make or to cause or direct to be made a full and true entry of the receipt or possession in its books and account; or

(b) concurs in failing to make any material entry in its books and account;

(2) knowingly concurs in making or publishing any written report, exhibit, or statement of its affairs or pecuniary condition containing any material statement that is false; or

(3) having the custody or control of its books, willfully refuses or neglects to make a proper entry in the books of that bank as required by law, to exhibit them, or allow them to be inspected and extracts to be taken from them by the department.

History: En. Sec. 40, Ch. 89, L. 1927; re-en. Sec. 6014.44, R.C.M. 1935; amd. Sec. 16, Ch. 431, L. 1975; amd. Sec. 8, Ch. 71, L. 1977; R.C.M. 1947, 5-519; amd. Sec. 2, Ch. 36, L. 1979; amd. Sec. 81, Ch. 382, L. 1997; amd. Sec. 17, Ch. 163, L. 2005.

Cross-References

Kinds of fraud, 28-2-404.
What constitutes actual fraud, 28-2-405.
What constitutes constructive fraud, 28-2-406.
Examination and supervision by Department, 32-1-211.
Special reports to Department, 32-1-233.
False statements and entries considered felony, 32-1-236.
Selection of officers and employees — meetings and minutes, 32-1-325.
Deposits in insolvent bank, 32-1-504.
Penalty for receiving deposits when insolvent or for making false statements, 32-1-505.
Felony charges — suspension or prohibition, 32-1-908.
Criminal law — knowingly defined, 45-2-101.
Felony defined, 45-2-101.
Felony — when no penalty specified, 46-18-213.

32-1-465. Limit on loans to officer, director, or principal shareholder. (1) Except as provided in subsection (2), a bank may not extend credit to an officer, director, or principal shareholder unless the extension of credit is in an amount that, when aggregated with the amount of all outstanding extensions of credit by that bank to all officers, directors, or principal shareholders, does not exceed the bank's unimpaired capital and unimpaired surplus.

(2) A bank with deposits of less than $100 million may by resolution of its board of directors increase the general limit in subsection (1) to a limit that does not exceed two times the bank's unimpaired capital and unimpaired surplus if:

(a) the board of directors determines that a higher limit is consistent with prudent, safe, and sound banking practices in light of the bank's experience in lending to officers, directors, and principal shareholders and is necessary to attract or retain directors or to prevent restricting the availability of credit in small communities;

(b) the resolution sets forth the facts and reasoning on which the board of directors bases the finding, including the amount of the bank's lending to officers, directors, and principal shareholders as a percentage of the bank's unimpaired capital and unimpaired surplus as of the date of the resolution;

(c) the bank has submitted the resolution to the department; and

(d) the bank meets or exceeds, on a fully phased-in basis, all applicable capital requirements established by the department.

History: En. Sec. 41, Ch. 89, L. 1927; re-en. Sec. 6014.45, R.C.M. 1935; R.C.M. 1947, 5-520; amd. Sec. 3, Ch. 36, L. 1979; amd. Sec. 33, Ch. 395, L. 1993; amd. Sec. 11, Ch. 265, L. 1995.

Cross-References

Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.
Theft, 45-6-301.
Issuing bad check, 45-6-316.
Misdemeanor — when no penalty specified, 46-18-212.

32-1-466. Purchase of obligation of bank by officer. A director, officer, agent, or other employee of any bank may not, directly or indirectly, for the person's own personal benefit, purchase, sell, or be interested in the purchase or sale of any obligation of the bank or of any of the assets of the bank for a sum less than the amount that appears upon the face of the obligation or obligations purchased or sold. Every person violating the provisions of this section shall, in addition to the general penalties of this chapter, forfeit to the state twice the nominal amount or face value of the obligations or assets purchased or sold.

History: En. Sec. 43, Ch. 89, L. 1927; re-en. Sec. 6014.47, R.C.M. 1935; R.C.M. 1947, 5-522; amd. Sec. 1013, Ch. 56, L. 2009.

Cross-References

Punishment, 32-1-110.
Purchase or loan of own capital stock prohibited, 32-1-335.

32-1-467. Loans to managing officer. (1) A bank may extend credit to a managing officer of the bank:

(a) in any amount to finance the education of the managing officer's children;

(b) in any amount to finance the purchase, construction, maintenance, or improvement of a residence of the managing officer if the extension of credit is secured by a first lien on the residence and the residence is:

(i) owned by the managing officer; or

(ii) expected to be owned by the managing officer after the extension of credit; and

(c) for any other purpose not specified in subsections (1)(a) and (1)(b) if the aggregate amount of loans to that individual under this subsection (1) does not exceed at any one time the greater of 2.5% of the bank's capital and unimpaired surplus or $25,000. However, in no event may the aggregate amount of loans to the individual exceed $100,000.

(2) The department may adopt rules to address loans made before October 1, 1993, and to define capital and unimpaired surplus for purposes of 32-1-465 and this section.

History: En. Sec. 45, Ch. 89, L. 1927; re-en. Sec. 6014.49, R.C.M. 1935; R.C.M. 1947, 5-524; amd. Sec. 34, Ch. 395, L. 1993; amd. Sec. 1, Ch. 17, Sp. L. November 1993.

Cross-References

Loan of money — what constitutes, 31-1-101.
Deceptive practices, 45-6-317.

32-1-468. Removal of directors, officers, or employees — hearing. (1) A director, officer, or employee of a bank who is found by the department, after examination, to be negligent, dishonest, reckless, or incompetent or to have violated 32-1-325, 32-1-464, 32-1-472, or 32-1-473 must be removed from office by the board of directors of the bank on the written order of the department. If the directors neglect or refuse to remove the director, officer, or employee and any losses accrue to the bank by reason of the negligence, dishonesty, recklessness, or incompetency of the director, officer, or employee, the written order of the department is conclusive evidence of the negligence of the directors failing to act as provided in this section in any action brought against the board of directors by a depositor or creditor for recovery of losses.

(2) If the board of directors refuses to remove the director, officer, or employee on order of the department, the board of directors may file a request for hearing pursuant to the Montana Administrative Procedure Act.

History: En. Sec. 109, Ch. 89, L. 1927; re-en. Sec. 6014.120, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1036; amd. Sec. 82, Ch. 382, L. 1997; amd. Sec. 18, Ch. 163, L. 2005; amd. Sec. 24, Ch. 75, L. 2019.

Cross-References

Negligence, 27-1-701, 27-1-702.

Removal of directors or officers of financial institutions, Title 32, ch. 1, part 9.

32-1-469 and 32-1-470 reserved.

32-1-471. Penalty for unlawful hypothecation of property received. Any officer or employee of any bank doing business in this state who, except in the manner authorized by law or the contract of the parties, pledges or in any way alienates any notes, stocks, bonds, mortgages, securities, or any other property coming into the officer's or employee's hands or into the possession of the bank as collateral, for safekeeping or in any other manner, and to which the bank has not acquired full title, is guilty of theft and upon conviction shall be punished as for other felonies.

History: En. Sec. 113, Ch. 89, L. 1927; re-en. Sec. 6014.124, R.C.M. 1935; amd. Sec. 42, Ch. 359, L. 1977; R.C.M. 1947, 5-1040; amd. Sec. 1014, Ch. 56, L. 2009.

Cross-References

Theft, 45-6-301.

Felony — when no penalty specified, 46-18-213.

32-1-472. Concealing actions from directors. Any officer or employee of any bank who intentionally conceals from the directors of such corporation, or committee thereof where the directors have delegated authority to a committee to pass on loans and discounts, any discount or loan made by and in behalf of the corporation or from its assets between the regular meetings of its board of directors or committee, the purchase of any security, the sale of any of its securities, or any guarantee, repurchase agreement, or any other agreement whereby the corporation is obligated, during the same period, is guilty of a misdemeanor and on conviction must be imprisoned in the county jail for not more than 12 months for each offense and may also be fined not more than $500, at the discretion of the court.

History: En. Sec. 114, Ch. 89, L. 1927; re-en. Sec. 6014.125, R.C.M. 1935; R.C.M. 1947, 5-1041.

Cross-References

What constitutes actual fraud, 28-2-405.

What constitutes constructive fraud, 28-2-406.

Classification of offenses, 45-1-201.

Misdemeanor defined, 45-2-101.

32-1-473. Theft of funds by directors, officers, or employees. A director, officer, or employee of a bank who fraudulently appropriates or abstracts or misapplies any of the money, funds, credits, or property of the bank when owned by it or held in trust or who issues or puts forth any certificate of deposit, draws any order or bill of exchange, makes any acceptance, assigns any note, bond, draft, bill of exchange, mortgage, judgment, or decree with intent to injure or defraud the bank or any person or corporation or to deceive any officer of the bank, any other person, or anyone appointed to examine the affairs of the bank or any other person who with like intent, aids or abets any director, officer, or employee in the violation of this section is guilty of theft and upon conviction shall be imprisoned in the state prison for a period of not to exceed 20 years or be fined an amount not to exceed $50,000, or both.

History: En. Sec. 117, Ch. 89, L. 1927; re-en. Sec. 6014.128, R.C.M. 1935; amd. Sec. 43, Ch. 359, L. 1977; R.C.M. 1947, 5-1044; amd. Sec. 7, Ch. 198, L. 1981; amd. Sec. 83, Ch. 382, L. 1997; amd. Sec. 19, Ch. 163, L. 2005.

Cross-References

What constitutes actual fraud, 28-2-405.
What constitutes constructive fraud, 28-2-406.
Felony defined, 45-2-101.
Theft, 45-6-301.

32-1-474. False statement to obtain loan. A person who makes a statement, knowing it to be false, for the purpose of obtaining for that person or for any other person, firm, corporation, or association a loan of money from any bank or for the purpose of gaining an extension of time for the payment of any debt due the bank shall be punished by a fine of not more than $1,000 or by imprisonment in the county jail for not more than 1 year, or both.

History: En. Sec. 118, Ch. 89, L. 1927; re-en. Sec. 6014.129, R.C.M. 1935; R.C.M. 1947, 5-1045; amd. Sec. 1015, Ch. 56, L. 2009.

Cross-References

What constitutes actual fraud, 28-2-405.
What constitutes constructive fraud, 28-2-406.
Misdemeanor defined, 45-2-101.
Deceptive practices, 45-6-317.

32-1-475 through 32-1-480 reserved.

32-1-481. Bank holidays. In addition to emergency closings authorized by 32-1-561 through 32-1-565, a bank in the state of Montana may remain closed and refrain from doing business on those legal holidays designated in 1-1-216.

History: En. Sec. 10, Pol. C. 1895; re-en. Sec. 10, Rev. C. 1907; amd. Sec. 1, Ch. 21, L. 1921; re-en. Sec. 10, R.C.M. 1921; Cal. Pol. C. Secs. 10-11; re-en. Sec. 10, R.C.M. 1935; amd. Sec. 1, Ch. 209, L. 1955; amd. Sec. 1, Ch. 6, L. 1965; amd. Sec. 1, Ch. 89, L. 1969; amd. Sec. 6, Ch. 32, L. 1971; amd. Sec. 1, Ch. 16, L. 1974; R.C.M. 1947, 19-107(part); amd. Sec. 1, Ch. 264, L. 1979; amd. Sec. 1, Ch. 435, L. 1983.

32-1-482. Transaction on holidays. Nothing in any law of this state shall in any manner whatsoever affect the validity of, or render void or voidable, the payment, certification, or acceptance of a check or other negotiable instrument or any other transaction by a bank in this state because done or performed during any time other than regular banking hours or on a legal holiday, provided that nothing shall be construed herein to compel any bank in this state, which by law or custom is entitled to close at 12 noon on any Saturday or for the whole or part of any legal holiday, to keep open for transaction of business or to perform any of the acts or transactions aforesaid on any Saturday after such hour or on any legal holiday except at its option.

History: En. Sec. 115, Ch. 89, L. 1927; re-en. Sec. 4016.126, R.C.M. 1935; R.C.M. 1947, 5-1042.

Cross-References

U.C.C. — bank deposits and collections — time of receipt of items, 30-4-107.
Effect of closing, 32-1-565.

32-1-483. Closing on Saturdays authorized — Saturday treated as holiday. Any bank as defined in 32-1-102 and any national bank or national banking association incorporated or organized under the laws of the United States of America and any federal reserve bank may, at its election, remain closed and refrain from the transaction of any business on Saturdays. Any Saturday on which any such bank remains closed shall be, with respect to such bank, a holiday and not a business day. Any act authorized, required, or permitted to be performed on a Saturday at or by or with respect to any bank including any national bank or national banking association and any federal reserve bank may be performed on the next succeeding business day, and no liability or loss of any rights of any kind shall result from such closing on Saturday or from the nonopening of any bank for the transaction of business on any Saturday under the authority of 32-1-483 through 32-1-485.

History: En. Sec. 1, Ch. 124, L. 1955; amd. Sec. 23, Ch. 71, L. 1977; R.C.M. 1947, 5-1055.

Cross-References

Effect of closing, 32-1-565.

32-1-484. Banking hours and business days. A bank may provide for its banking hours or business days by giving reasonable notice to the public and providing a copy of the notice to the department.

History: En. Sec. 2, Ch. 124, L. 1955; R.C.M. 1947, 5-1056; amd. Sec. 35, Ch. 395, L. 1993.

Cross-References
Publication of legal notices, Title 18, ch. 7, part 2.
Bylaws, 32-1-308.
Effect of closing, 32-1-565.

32-1-485. Interest payable at bank on Saturday — how paid. Where, by the terms of any note or obligation, interest is payable to a bank on any Saturday upon which a bank is closed pursuant to the authority of 32-1-483 through 32-1-485, interest payable to such bank on any such Saturday may be paid in the amount due on such Saturday on the next succeeding business day with the same effect as if paid to such bank on such Saturday.

History: **En. Sec. 3, Ch. 124, L. 1955; R.C.M. 1947, 5-1057.**

Cross-References
Interest on deposits of public funds — conformity with federal law, 17-6-104.
U.C.C. — bank deposits and collections — time of receipt of items, 30-4-107.
Loan presumed to be on interest, 31-1-103.
Interest defined, 31-1-104.

32-1-486 through 32-1-490 reserved.

32-1-491. Destruction of records. (1) Banks are required to preserve or keep their records of customer accounts for at least 8 years after January 1 of the year following the time that the records are made. However, records showing unpaid balances in favor of depositors of a bank may not be destroyed. Liability may not accrue against a bank destroying any records, except records of which destruction is forbidden by this section, after the expiration of the time provided in this section.

(2) The department shall adopt rules providing for retention schedules for bank records other than those records listed in subsection (1).

History: **En. Sec. 1, Ch. 77, L. 1951; R.C.M. 1947, 5-1050; amd. Sec. 1, Ch. 314, L. 1983; amd. Sec. 84, Ch. 382, L. 1997; amd. Sec. 20, Ch. 163, L. 2005.**

Cross-References
Adoption and publication of rules, Title 2, ch. 4, part 3.
Examination and supervision by Department, 32-1-211.
Department to make rules, 32-1-218.

32-1-492. Definitions — reproduction of bank records — admissibility in evidence — cost recovery. (1) (a) For the purposes of this section, "bank records" includes any document, paper, letter, book, map, photograph, sound or video recording, magnetic tape, electronic-storage medium, or other information- recording medium used in a bank's normal course of business.

(b) (i) For the purposes of this section, "electronic storage" means the recording, storage, retention, maintenance, and reproduction of documents using microfilm, microfiche, data processing, computers, or other electronic process that correctly and legibly stores and reproduces documents.

(ii) A photographic, photostatic, miniature photographic copy, or reproduction of any kind, including electronic or computer-generated data that has been electronically stored and is capable of being converted into written form, must be considered an original record for all purposes and must be treated as an original record in all courts and administrative agencies for the purposes of admissibility in evidence.

(iii) A facsimile, exemplification, or certified copy of any reproduction referred to in subsection (1)(b)(ii) must, for all purposes, be considered a facsimile, exemplification, or certified copy of the original record.

(2) Except as provided in subsection (6), banks are authorized to make, at any time, photographic or photostatic copies or microfilm reproductions of any records or documents, including photographic enlargements and prints of microfilms, to be preserved, stored, used, and employed in carrying on business.

(3) In an action or proceeding in which bank records may be called in question or be demanded of a bank or any officer or employee of a bank, a showing that the records have been destroyed in the regular course of business is a sufficient excuse for the failure to produce the records.

(4) Upon the showing required in subsection (3), secondary evidence of the form, text, and contents of the original records, including photostatic, photographic, or microfilm reproductions, photographic enlargements, and prints of microfilm reproductions, when made in the regular

course of business, is admissible in evidence in any court of competent jurisdiction or in any administrative proceeding.

(5) Any photostatic, photographic, or microfilm reproductions, including enlargements of the microfilm reproductions, made in the regular course of business of any original files, records, books, cards, tickets, deposit slips, or memoranda that were in existence on July 1, 1951, are admissible in evidence as proof of the form, text, and content of the originals that were destroyed in the regular course of business.

(6) A bank may, as a condition of providing bank records to a third party in response to a subpoena or to another legal procedure or request, charge and collect the actual costs incurred in locating, reproducing, and providing the bank records.

History: En. Sec. 2, Ch. 77, L. 1951; R.C.M. 1947, 5-1051; amd. Sec. 1, Ch. 237, L. 1997; amd. Sec. 85, Ch. 382, L. 1997; amd. Sec. 6, Ch. 100, L. 1999; amd. Sec. 21, Ch. 163, L. 2005.

Cross-References

Entries in official books and records prima facie evidence, 26-1-605.
Entry made by officer or board prima facie evidence, 26-1-606.
Records of electronic funds transfers, 32-6-301.

32-1-493. Admissibility of copies in evidence — exception when original available. Any photostatic or photographic or microfilm reproductions (including enlargements of the latter) of any original records or files of any bank, whether in the form of an entry or entries in a book or any other form of record, shall be admissible in evidence in any court of competent jurisdiction in proof of an act, transaction, occurrence, or event when shown to be made in the regular course of business of the bank. But nothing contained in 32-1-491 through 32-1-495 shall be construed to authorize the use of secondary evidence in administrative or court proceedings when original records are in existence and available for use in accord with the rules of evidence.

History: En. Sec. 3, Ch. 77, L. 1951; R.C.M. 1947, 5-1052.

Cross-References

Records of electronic funds transfers, 32-6-301.

32-1-494. Destruction or reproduction "in regular course of business" defined. Destruction in the regular course of business shall include destruction at any time after making such reproductions. Reproductions made in the regular course of business shall include reproductions made at any time prior to the destruction of the original, in each case, if done in good faith and without intent to defraud.

History: En. Sec. 4, Ch. 77, L. 1951; R.C.M. 1947, 5-1053.

Cross-References

U.C.C. — good faith defined, 30-1-201.

32-1-495. Application. The provisions of 32-1-491 through 32-1-495 shall be applicable to all records in existence on February 23, 1951, and to all records originating after said date and shall apply to all banks organized under the laws of the state of Montana and also to all national banks located in the state of Montana, as far as applicable to such national banks.

History: En. Sec. 5, Ch. 77, L. 1951; R.C.M. 1947, 5-1054.

Cross-References

Change from state to national bank, 32-1-361.
National bank powers extended to state banks, 32-1-362.
Certificate of change to national bank, 32-1-365.
Reorganization of national bank as state bank, 32-1-374.

Part 5
Dissolution, Closing, and Liquidation

Part Cross-References

Receivers, Title 27, ch. 20.

32-1-501. Dissolution and disincorporation. Commercial banks, savings banks, trust companies, and investment companies may be dissolved in the manner provided by the laws of this state applicable to the dissolution of other corporations. However, a bank or trust company may, upon a vote of two-thirds of its stockholders at a special meeting called for that purpose in accordance with its bylaws, voluntarily quit business and liquidate upon the payment of its debts, exclusive of liability to stockholders, or upon agreement with all of its creditors to a plan of liquidation. A bank or trust company that wishes to voluntarily liquidate shall apply to the department for permission to liquidate and, in addition to complying with the laws of this state governing the liquidation of corporations, shall comply in all respects with the requirements or rules of the department governing voluntary dissolution. The board of directors of a bank or trust company whose stockholders have voted to place it in voluntary liquidation shall appoint a liquidating agent to wind up the affairs of the bank or trust company. The liquidating agent, on authority of the board of directors, may execute deeds for the transfer of real property and do all things necessary to carry out the proper liquidation of the bank or trust company. Nothing in this section prevents the department from taking charge at any time when in its opinion the interest of creditors or stockholders is not being protected. The decision of the department in these matters is controlling.

History: En. Sec. 20, Ch. 89, L. 1927; amd. Sec. 2, Ch. 145, L. 1931; amd. Sec. 1, Ch. 10, L. 1935; re-en. Sec. 6014.24, R.C.M. 1935; amd. Sec. 10, Ch. 431, L. 1975; R.C.M. 1947, 5-301; amd. Sec. 86, Ch. 382, L. 1997; amd. Sec. 22, Ch. 163, L. 2005.

32-1-502. Grounds for closing bank. (1) When it appears to the department that:

(a) a bank has willfully violated its charter or a law of this state;

(b) a bank has willfully violated a general rule of the department, made in accordance with law;

(c) the capital of a bank is impaired or for any reason is below the amount required by law and has not been made good after notice, as provided by law, or, without that notice, in the event a majority of the board of directors of the bank notifies the department in writing that the impairment cannot be made good;

(d) a bank cannot meet or has failed to meet its liabilities as they become due in the regular course of business;

(e) a bank's reserve has fallen below the amount required by law and it has failed to make good that reserve within 30 days after being requested to do so by the department or, without that notice, if a majority of the directors, in writing, notifies the department that the reserve cannot be made good within 30 days or if it is continually allowing its reserve to fall below the required amount;

(f) a bank is conducting business in an unsafe and unauthorized manner or is in an unsafe or unsound condition;

(g) a bank refused to submit its papers, books, and concerns to the inspection of the department; or

(h) an officer of a bank has refused to be examined under oath regarding the affairs, business, or concerns of any bank insofar as they relate to solvency or matters having to do with the supervision by the department; then the department may, in its discretion, close the bank and take possession of all the books, records, assets, and business of every description of the bank and hold them and retain possession of them until the bank is authorized by the department to resume business or its affairs are liquidated as provided in this chapter, and it shall do so in cases where a bank comes into its possession voluntarily or in the manner provided by law.

(2) The powers and authority conferred on the department by this section, except in cases of voluntary surrender, are discretionary and not mandatory. As long as the department acts in good faith, the department and its employees and agents may not be held liable civilly or criminally or upon their official bonds for action taken under this section or for any failure to act under it.

History: En. Sec. 121, Ch. 89, L. 1927; re-en. Sec. 6014.131, R.C.M. 1935; amd. Sec. 43, Ch. 431, L. 1975; R.C.M. 1947, 5-1101.

Cross-References

Extent of surety's liability, 28-11-411.
Examination and supervision by Department, 32-1-211.
Department to make rules, 32-1-218.
Reserve requirements, 32-1-455.
Fraud by director, officer, or employee, 32-1-464.

32-1-503. Bank insolvent when. A bank is insolvent within the meaning of this chapter when all of its capital, surplus, and undivided profits are absorbed in losses and the remaining assets are not sufficient to pay and discharge its contracts, debts, and engagements.

History: En. Sec. 88, Ch. 89, L. 1927; re-en. Sec. 6014.99, R.C.M. 1935; R.C.M. 1947, 5-1015.

Cross-References

Insolvency — what constitutes, 31-2-202.

32-1-504. Deposits in insolvent bank. (1) Except as otherwise provided by the Uniform Commercial Code, whenever any bank shall be insolvent in the manner described and set forth in this chapter, such bank shall not accept or receive on deposit any money, bank bills or notes, United States treasury notes or currency, or other notes, bills, or drafts circulating as money or currency or transact any other business in connection with its operations, except as trustee for the depositors and parties transacting business with them, and it or they shall keep all such deposits of money, bills or notes, or United States treasury notes or currency, or other notes, bills, or drafts circulating as money or currency separate and apart from the general assets of the bank from and after the date of the accrual of such insolvency. When such impairment or insolvency has been made good, such deposits received in trust may be transferred to the general assets of the bank on and by written consent of the department.

(2) In the event such insolvency be not made good, then any and all such trust deposits shall be returned to the depositors making them.

(3) Any officer, director, cashier, manager, member, partner, or managing partner thereof who shall knowingly accept or receive, be accessory to, or permit or connive at the receiving or accepting of such trust deposits, except in the manner hereinbefore set forth in this section, shall be deemed guilty of a felony and upon conviction thereof shall be punished by a fine not exceeding $10,000 or imprisonment in the state prison not exceeding 5 years or by both fine and imprisonment.

History: En. Sec. 70, Ch. 89, L. 1927; re-en. Sec. 6014.74, R.C.M. 1935; amd. Sec. 11-102, Ch. 264, L. 1963; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-803.

Cross-References

Money defined, 30-1-201.
U.C.C. — bank deposits and collections — insolvency and preference, 30-4-214.
Investments of financial institutions, 32-1-424.
Fraud by director, officer, or employee, 32-1-464.
Classification of offenses, 45-1-201.
Felony defined, 45-2-101.

32-1-505. Penalty for receiving deposits when insolvent or for making false statements. (1) Any officer, agent, or clerk of any bank, knowing such bank to be insolvent, who receives money, bank bills, notes of the United States, or currency or other bills or drafts circulating as money or currency, except in the manner set forth in 32-1-504; subscribes or makes any false statements or entries in the books of such bank; knowingly subscribes or exhibits any false paper with the intent to deceive any person authorized to examine as to the condition of such bank; or willfully subscribes or makes false reports is subject to imprisonment in the state prison for a term not exceeding 5 years, a fine not exceeding $50,000, or both.

(2) Any person or the members of any partnership or banking association who willfully or knowingly receive deposits, money, or commercial papers circulating as money, when such person, partnership, or banking association is insolvent, or who subscribe or make any false statement or entries in the books of any such bank or who knowingly subscribe or exhibit any false papers with the intention of deceiving any person authorized to examine the condition of any bank provided for in this chapter or who willfully subscribe or make false reports to the department shall be guilty of a felony and shall be punishable by imprisonment in the state prison for a term not exceeding 5 years, by a fine not exceeding $50,000, or by both such fine and imprisonment.

History: (1)En. Sec. 69, Ch. 89, L. 1927; re-en. Sec. 6014.73, R.C.M. 1935; amd. Sec. 16, Ch. 71, L. 1977; Sec. 5-802, R.C.M. 1947; (2)En. Sec. 87, Ch. 89, L. 1927; re-en. Sec. 6014.98, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; Sec. 5-1014, R.C.M. 1947; R.C.M. 1947, 5-802, 5-1014; amd. Sec. 7, Ch. 198, L. 1981.

Cross-References

Punishment, 32-1-110.
False statements and entries considered felony, 32-1-236.
Fraud by director, officer, or employee, 32-1-464.
Felony defined, 45-2-101.
Unsworn falsification to authorities, 45-7-203.

32-1-506. Assessment on capital stock to make good impairment. (1) When the department determines that an impairment of capital exists in a bank, the department may notify the board of directors of the bank by written notice that the impairment exists, stating the amount of the impairment in dollars and percentage of the capital stock. The department may order the board to make good the impairment within 90 days from date of the notice.

(2) The board of directors shall, upon receipt of notice, convene and pass a resolution reciting the receipt of the notice of impairment and calling a special meeting of the stockholders of the bank in the manner provided in their bylaws.

(3) The stockholders at the meeting shall pass a resolution reciting the facts of receipt of notice from the department, notice of impairment, and notice of meeting and assessing themselves by assessing the stock of record. Payment of the assessment must be made within the time limit specified by the department in the notice of impairment.

(4) If there is any stock remaining on which the assessment is not paid as provided in this section, the stock or a part of the stock that is necessary to pay the assessment must be sold by the board of directors, acting through the cashier or secretary of the bank, at public or private sale, as appears best for all concerned, not less than 30 days after the day fixed for payment of assessment.

(5) Notice of the time and place of the sale must be given by common courier with tracking capability to the stockholders by the board through the bank's cashier or secretary at least 14 days prior to the sale.

(6) A sale of stock as provided in this section causes an absolute cancellation of the outstanding certificate or certificates evidencing the stock sold and makes them void in the hands of the stockholder or the stockholder's assigns or pledgees.

(7) The bank shall issue a new certificate:

(a) to the purchaser for the number of shares purchased; and

(b) to the stockholder of record. The new certificate must be delivered to the purchaser, stockholder, or any pledgee or assignee of the stock for the remaining shares, if any.

(8) The record of the original certificate sold must be marked canceled on the records of the bank, and that record is prima facie evidence of the regularity of the proceedings for the sale of the stock.

(9) If a bank fails to make good its capital impairment on demand of the department, as provided in this section, the department may immediately take charge of that bank and proceed to liquidate it as in the case of insolvency.

(10) If the stock does not sell for enough to pay the assessment that is owed, the board of directors may sue in the name of the corporation to collect the deficiency from the stockholder of record whose stock has been sold for the assessment.

History: En. Sec. 68, Ch. 89, L. 1927; re-en. Sec. 6014.72, R.C.M. 1935; amd. Sec. 29, Ch. 431, L. 1975; R.C.M. 1947, 5-801; amd. Sec. 4, Ch. 36, L. 1979; amd. Sec. 1016, Ch. 56, L. 2009; amd. Sec. 9, Ch. 49, L. 2013; amd. Sec. 25, Ch. 75, L. 2019.

Cross-References

Reports to Department, 32-1-231.
Special reports to Department, 32-1-233.
Purchase or loan of own capital stock prohibited, 32-1-335.

32-1-507. Power of closed banks to borrow money from governmental agencies. (1) Except as provided in subsection (2), after applying to and obtaining the approval of the department and the district court of the county in which the bank or trust or investment company is located, the liquidating agents of closed banks may borrow money from an agency of the federal government on behalf of commercial banks, savings banks, trust companies, and investment companies closed and in liquidation. As security for the loan the liquidating agent may pledge or mortgage assets and properties for the purpose of paying depositors or creditors in part or in full.

(2) If the federal deposit insurance corporation is appointed as the liquidating agent, the reporting and district court approval requirements of subsection (1) do not apply.

History: En. Sec. 1, Ch. 3, Ex. L. 1933; re-en. Sec. 6015.1, R.C.M. 1935; amd. Sec. 62, Ch. 431, L. 1975; amd. Sec. 26, Ch. 71, L. 1977; R.C.M. 1947, 5-1126; amd. Sec. 36, Ch. 395, L. 1993.

Cross-References

Closed banking institutions empowered to borrow from corporation, 32-1-606.

32-1-508. Corporate existence — ceases when. The charters and the corporate existence of banks shall cease automatically and become nonexistent upon the completion of liquidation of the affairs of said bank, whether accomplished voluntarily or through legal process. For the purposes of this section, a bank's affairs shall be considered liquidated and completed when all of its property of every kind has been sold or applied toward the payment of its obligations and the corporation is left without property in existence or in reasonable expectancy.

History: **En. Sec. 106, Ch. 89, L. 1927; re-en. Sec. 6014.117, R.C.M. 1935; R.C.M. 1947, 5-1033.**

32-1-509. Taxes on banks which have ceased to do business. Whenever any bank ceases to do business as a bank, no taxes shall be levied or collected in accordance with the laws governing the assessment of banks but its property shall be assessed in accordance with the laws governing the assessment of similar property of private corporations.

History: **En. Sec. 95, Ch. 89, L. 1927; re-en. Sec. 6014.106, R.C.M. 1935; R.C.M. 1947, 5-1022.**

Cross-References

Taxation — return and payment on corporate dissolution, 15-31-143.
Taxation — banks and savings and loan associations, Title 15, ch. 31, part 7.

32-1-510. Penalty for maliciously declaring bank insolvent. If, as a result of malice or for personal gain, an employee or agent of the department declares a bank insolvent, the employee or agent is subject to a fine not exceeding $1,000 or imprisonment in the county jail not exceeding 1 year, or both, and shall forfeit the employee's or agent's office.

History: **En. Sec. 122, Ch. 89, L. 1927; re-en. Sec. 6014.132, R.C.M. 1935; amd. Sec. 44, Ch. 431, L. 1975; R.C.M. 1947, 5-1102; amd. Sec. 1017, Ch. 56, L. 2009.**

Cross-References

Rules of conduct for state officers and state employees, 2-2-121.
Punishment, 32-1-110.
Examination and supervision by Department, 32-1-211.
Confidentiality — penalties, 32-1-234.
Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.

32-1-511. Bank may be placed in department's possession. A bank may place its affairs and assets under the control and in the possession of the department by posting a notice on the front door of the bank indicating that it is in the possession of the department. The notice shall be signed by a majority of the directors in office of the bank. Immediately upon the posting of the notice by a bank, it shall notify the department of its action.

History: **En. Sec. 123, Ch. 89, L. 1927; re-en. Sec. 6014.133, R.C.M. 1935; amd. Sec. 45, Ch. 431, L. 1975; R.C.M. 1947, 5-1103.**

Cross-References

Examination and supervision by Department, 32-1-211.

32-1-512. Effect of posting notice. The posting of the notice by the directors of a bank or of a like notice by the department is sufficient to place all assets and property of the bank, of whatever nature and wherever located, in possession of the department and operates as a bar to an attachment or other legal proceedings against the bank or its assets. No valid lien or claim can be acquired or created, or transfer or assignment made in any manner, binding or affecting any of the assets of the bank after the posting of the notice or after taking possession of a bank by the department without its consent.

History: **En. Sec. 124, Ch. 89, L. 1927; re-en. Sec. 6014.134, R.C.M. 1935; amd. Sec. 46, Ch. 431, L. 1975; R.C.M. 1947, 5-1104.**

Cross-References

Receivers, Title 27, ch. 20.
Attachments prohibited, 32-1-111.
Liens — general provisions, Title 71, ch. 3, part 1.

32-1-513. Taking possession of bank — notice. On taking possession of the assets and business of the bank, the department shall, in addition to posting notice on the front door of the bank, also notify, personally, by mail or by wire, all corresponding banks and all persons or corporations known to be in possession of any of the estate of the bank.

History: **En. Sec. 125, Ch. 89, L. 1927; re-en. Sec. 6014.135, R.C.M. 1935; amd. Sec. 47, Ch. 431, L. 1975; R.C.M. 1947, 5-1105; amd. Sec. 37, Ch. 395, L. 1993.**

Cross-References

Notice — actual and constructive, 1-1-217.
Examination and supervision by Department, 32-1-211.

32-1-514. Resumption after closing. After the department has taken possession of a bank, it may permit that bank to resume business upon conditions which may be approved by the department.

History: En. Sec. 126, Ch. 89, L. 1927; re-en. Sec. 6014.136, R.C.M. 1935; amd. Sec. 48, Ch. 431, L. 1975; amd. Sec. 24, Ch. 71, L. 1977; R.C.M. 1947, 5-1106.

Cross-References

Examination and supervision by Department, 32-1-211.
Reserve requirements, 32-1-455.

32-1-515. Powers of department on closing bank — court proceedings. (1) Upon taking the assets and business of a bank into its possession, the department is authorized to collect all money due to the bank and to do other acts necessary to conserve the bank's assets and business. The department shall proceed to liquidate the affairs of the bank.

(2) The department may, except as limited by the terms of this chapter, do any acts necessary or desirable for the protection of the property and assets of the bank, the speedy and economical liquidation of the assets and affairs of the bank, the payment of creditors, or the reopening and resumption of business when that is practicable or desirable.

(3) The department may institute, in its own name or in the name of the bank, legal proceedings it considers expedient for the purposes of subsection (1).

(4) (a) By applying to the district court of the county in which the bank is located or to the judge of that court, the department may obtain an order to sell, compromise, or compound any bad or doubtful debt or claim and to sell and dispose of any assets. The sale may be made to stockholders, officers, directors, or others interested in the bank on consent of the court.

(b) In the court proceedings the bank must be made a party by notice issued on order of the court or judge, in place of summons, and served upon an officer of the bank if there is an officer in the county.

(5) If the federal deposit insurance corporation is appointed as the liquidating agent, subsection (4) does not apply.

History: En. Sec. 127, Ch. 89, L. 1927; re-en. Sec. 6014.137, R.C.M. 1935; amd. Sec. 49, Ch. 431, L. 1975; R.C.M. 1947, 5-1107; amd. Sec. 38, Ch. 395, L. 1993.

Cross-References

Notice — actual and constructive, 1-1-217.
Examination and supervision by Department, 32-1-211.

32-1-516. Recourse of aggrieved bank — injunction. (1) A bank aggrieved by the action of the department in taking possession of its assets or closing its doors may, within 14 days after possession has been taken, apply to the district court of the county in which its principal place of business is located, or to the judge of that court in chambers, to enjoin further proceedings by the department.

(2) The court or the judge in chambers, after notifying the department to appear at a specified time and place to show cause why further proceedings should not be enjoined and after hearing the allegations and proofs of the parties and determining facts, may on the merits dismiss the application or enjoin the department from further proceeding and direct it to surrender the business and assets of the bank.

(3) The application for injunction may be heard at any time after 5 days' notice from the time of service on the department, in the discretion of the court, or at any time prior to then by the consent of the department.

(4) Application shall be made on the verified complaint of the bank, in the form used in civil actions, and a copy of the complaint shall be served on the department with the order to show cause.

(5) The department shall, at least 2 days before the time set for hearing, file with the court and serve upon counsel for plaintiff an answer to the complaint, also in the form used in civil actions. Any questions raised by motion in other actions may be raised in the answer.

(6) On the issues raised by the complaint and answer, the court or the judge at chambers, at the time fixed for showing cause, shall try the matter on the merits by hearing the allegations and proofs of the parties and shall enter judgment, as in the trial of other civil actions.

(7) If the department makes no appearance in the time allowed, the court shall enter its default and proceed to hear the proofs of the plaintiff as in civil actions under similar

circumstances and enter judgment accordingly. The judgment entered either after hearing on the merits or by default is a final judgment.

(8) During the pendency of litigation the department shall take that action in relation to the assets of the bank which is necessary to conserve them.

History: En. Sec. 128, Ch. 89, L. 1927; re-en. Sec. 6014.138, R.C.M. 1935; amd. Sec. 50, Ch. 431, L. 1975; R.C.M. 1947, 5-1108; amd. Sec. 10, Ch. 49, L. 2013.

Cross-References

Injunctions, Title 27, ch. 19.

32-1-517. Department may retain bank employees — liquidating agent's salary and expenses. (1) The department may retain those officers or employees of the bank which it considers necessary. It shall require from the agent appointed by it and from those assistants who have charge of any of the assets of the bank that security for the faithful discharge of their duties as it considers proper.

(2) The salary of a liquidating agent and necessary clerical assistance and other expenses incurred by a liquidating agent shall be borne equally and ratably by the bank or banks in process of liquidation under the agent's charge in proportion to the total amount of resources of each of the banks. The funds for those expenses shall be raised by assessing each bank in ratio herein set forth and paying those expenses direct to the persons entitled to them, without depositing any of the funds in the state treasury.

History: En. Sec. 129, Ch. 89, L. 1927; re-en. Sec. 6014.139, R.C.M. 1935; amd. Sec. 51, Ch. 431, L. 1975; R.C.M. 1947, 5-1109.

Cross-References

Agency, Title 28, ch. 10.
Selection of officers and employees — minutes and meetings, 32-1-325.
Bonding of employees, 32-1-461.

32-1-518. Compensation of agents and attorneys. (1) Except as provided in subsection (2), after notice to the bank and subject to approval by a district court judge of the county in which the bank is located, the compensation of the agents, attorneys, expert accountants, and other assistants appointed by the department and all expenses of liquidation and distribution of a bank whose assets and business have been taken possession of by the department must be fixed by the department. The department shall, upon written request of the judge, supply semiannual statements showing the condition of the bank in process of liquidation. Except in cases of emergency, the compensation paid to attorneys and expert accountants must be fixed and approved before services are rendered. The compensation must be paid out of the funds of the bank in the hands of the department and are a proper charge and lien on the assets of the bank.

(2) If the federal deposit insurance corporation is appointed as the liquidating agent, the reporting and district court approval requirements of subsection (1) do not apply.

History: En. Sec. 130, Ch. 89, L. 1927; re-en. Sec. 6014.140, R.C.M. 1935; amd. Sec. 52, Ch. 431, L. 1975; R.C.M. 1947, 5-1110; amd. Sec. 39, Ch. 395, L. 1993.

Cross-References

Attorney fees, Title 25, ch. 10, part 3.
Agency, Title 28, ch. 10.
Liens generally, Title 71, ch. 3, part 1.

32-1-519 through 32-1-530 reserved.

32-1-531. Notice to creditors of insolvent bank. (1) Except as provided in subsection (2), the department shall give notice by advertisement in a newspaper of general circulation in the town or city in which the bank is situated, if there is one, and, if not, then in some other newspaper published in this state, which the department shall designate, once a week for 2 successive weeks. The notice must call on all persons who have claims against the bank to present them to the department or its authorized agent at a place specified in the notice and to make sworn proof, in a form to be fixed by the department, within the time specified in the notice, not less than 90 days from the date of the first publication. A copy of the notice must be mailed to all persons whose names appear as creditors upon the books of the bank.

(2) If the federal deposit insurance corporation is appointed as the liquidating agent, the provisions of subsection (1) do not apply and notice to creditors must be given pursuant to federal law.

History: **En. Sec. 131, Ch. 89, L. 1927; re-en. Sec. 6014.141, R.C.M. 1935; amd. Sec. 53, Ch. 431, L. 1975; R.C.M. 1947, 5-1111; amd. Sec. 40, Ch. 395, L. 1993.**

Cross-References

Publication of legal notices, Title 18, ch. 7, part 2.

Assignments for benefit of creditors — notice to creditors to present claims, 31-2-221.

32-1-532. Claims — allowance and rejection. (1) Except as provided in subsection (6), the department shall reject or allow all claims in whole or in part and on each claim allowed shall designate the order of its priority.

(2) If a claim is rejected or an order of priority allowed lower than that claimed, notice must be given the claimant personally or by common courier with tracking capability and an affidavit of the service of the notice, which is prima facie evidence of service, must be filed in the office of the department.

(3) The action of the department is final unless an action is brought by the claimant against the bank in the district court of the county in which the bank is located within 90 days after service. An appeal from the department's allowance may also be taken by any party in interest by serving notice on the department, stating the grounds of objection and filing an action in that court within 30 days after allowance.

(4) Within 5 days after the notice, the department shall file in the court and serve on the appellant a copy of the claim and its reasons for allowance.

(5) The court shall, after 5 days' notice of time and place of hearing on the issues raised, hear the proof of the parties and enter judgment reversing, affirming, or modifying the department's action.

(6) If the federal deposit insurance corporation is appointed as the liquidating agent, the provisions of subsections (1) through (5) do not apply and notice to creditors must be given pursuant to federal law.

History: **En. Sec. 132, Ch. 89, L. 1927; re-en. Sec. 6014.142, R.C.M. 1935; amd. Sec. 54, Ch. 431, L. 1975; R.C.M. 1947, 5-1112; amd. Sec. 41, Ch. 395, L. 1993; amd. Sec. 26, Ch. 75, L. 2019.**

Cross-References

U.C.C. — secured transactions — perfection and priority of security interests, Title 30, ch. 9A, part 3.

32-1-533. Payment of claims. (1) Claims presented to the department prior to the expiration of the time fixed in the notice to creditors and allowed by it shall be paid in the order of priority fixed in this chapter.

(2) Those filed after that expiration and within 1 year of that expiration are entitled, after they have been allowed by the department, to share in the distribution of the assets of the bank only to the extent of the assets undistributed in the hands of the department and available for the payment of claims of their order of priority at the time the claims are filed. As against other claims of the same order of priority on which dividends have been paid, they are entitled to payment in a proportionate amount before further payments are made on those other claims.

(3) All claims filed after the expiration of 1 year following the date fixed in the notice to creditors as the time for presentation of claims are not entitled to be allowed or paid unless all other creditors' claims of any kind, except claims of shareholders based on stock or assessments paid on stock, have been fully paid and a surplus remains in the hands of the department and then only from that surplus.

History: **En. Sec. 133, Ch. 89, L. 1927; re-en. Sec. 6014.143, R.C.M. 1935; amd. Sec. 55, Ch. 431, L. 1975; R.C.M. 1947, 5-1113.**

Cross-References

Assignments for benefit of creditors, Title 31, ch. 2, part 2.

32-1-534. Claims — order of payment — priorities. (1) Except as otherwise provided by the Uniform Commercial Code, the order of payment of the debts of a bank liquidated by the department is as follows:

(a) the expense of liquidation, including compensation of agents, employees, and attorneys;

(b) all funds of any other bank in process of liquidation by the department and placed on deposit by the department;

(c) all funds held by the bank in trust;

(d) debts due depositors or holders of cashier's checks, certified checks, and drafts on correspondent banks, including protest fees paid by them on valid checks or drafts presented after closing of the bank, pro rata. All deposit balances of other banks or trust companies and all deposits of public funds of every kind (except those actually placed on special deposit under the statutes providing for deposit), including those of the United States, the state of Montana, and every county, district, municipality, political subdivision, or public corporation of this state, whether secured or unsecured or whether deposited in violation of law or otherwise, are included within the terms of this subsection (1)(d) and take the same priority as debts due any other depositor. Accrued interest on savings accounts, certificates of deposit, or other interest-bearing contracts, up to the time of the closing of the bank, is considered as part of the debt due.

(e) interest on the classes of claims contained in subsections (1)(a) through (1)(d) without regard to the priority computed from the date of closing of the bank at the rate of 7% a year;

(f) unliquidated claims for damages and similar claims, including claims of stockholders for amounts claimed to have been voluntarily advanced to the bank or paid in by way of special or voluntary or other assessments.

(2) The department may, in its discretion, without regard to the priorities fixed in subsections (1)(c) through (1)(f) or in preference to the payment of any claims of creditors within these subsections, pay off and discharge any lien, claim, or charge against the assets or property of the bank in its hands and pay those sums it considers necessary for the preservation, maintenance, conservation, and protection of those assets and property and property on which the bank has liens by mortgage or otherwise. The department may create a fund or retain, in preference to the claim of any creditors in subsections (1)(c) through (1)(f), money for those purposes.

(3) Collateral that has been put up or pledged as security for the payment of bills payable by a bank or loans or discounts that have been outstanding as rediscounts of a bank prior to the closing of it is not available to the other creditors of the bank in whole or in part until the bills payable or rediscounts have been retired, after which offsets as provided in this section must be allowed.

(4) Deposits of a person, firm, or corporation in a bank that is in the possession of the department may be offset against any indebtedness (subject to the conditions of subsection (3)), except assessments on stock, due to the bank from that person, firm, or corporation. All dividends when declared in favor of a creditor of the bank may be applied, in the discretion of the department, in satisfaction of the indebtedness, if any, due the bank from the creditor.

History: En. Sec. 134, Ch. 89, L. 1927; amd. Sec. 4, Ch. 145, L. 1931; re-en. Sec. 6014.144, R.C.M. 1935; amd. Sec. 11-104, Ch. 264, L. 1963; amd. Sec. 56, Ch. 431, L. 1975; R.C.M. 1947, 5-1114; amd. Sec. 5, Ch. 36, L. 1979; amd. Sec. 42, Ch. 395, L. 1993.

Cross-References

Security for deposits of public funds, 17-6-103.
Powers of receiver, 27-20-302.
U.C.C. — bank deposits and collections — insolvency and preference, 30-4-214.
U.C.C. — secured transactions — perfection and priority of security interests, Title 30, ch 9A, part 3.
Certified checks, 32-1-441.
Giving security for deposit prohibited — exceptions, 32-1-447.

32-1-535. Claims — partial payments — assignments. (1) The department need not await the expiration of the time allowed for filing claims, as fixed in the notice to the creditors, for the payment of dividends. The department may, if under the circumstances of the particular case it considers it expedient and safe, at any time after taking possession of the bank and prior to the expiration of the period fixed for filing of claims and if it has on hand in cash sufficient funds in excess of the expenses of liquidation, make pro rata distribution to any class of creditors entitled to distribution in the order of priority fixed in this chapter. The department shall make a payment to the creditors as they appear on the books and records of the bank and after determining the priority and basing its apportionment on the amount shown to be due by the books and records.

(2) At any time after the expiration of the date fixed for the presentation of claims against the bank and from time to time after that date when, in its discretion, there are sufficient funds available, the department shall, after making proper provisions for the payment of expenses of liquidation, declare and pay dividends to all creditors of the bank pro rata in the order of their priority. If, after the time fixed for presentation of claims against the bank has expired, it appears that a person, prior to the expiration of the period or at any other time, has been paid

more than the pro rata amount due the person as compared with the amounts paid to other creditors, nothing more may be paid to that creditor until the payment made to other creditors places them on equal footing.

(3) In calculating dividends, all disputed claims and deposits must be taken into account and the amount of dividends upon the disputed claims or deposits must be held by the department until the validity of those claims or deposits has been finally determined.

(4) Claims against a bank in process of liquidation may be assigned in whole or in part subject to the approval of the department. Assignments of claims are binding upon the department only after they have been filed and allowed by the department and are subject to the payment of the assignor's liabilities to the bank. An assignment must be made by filing written notice, signed by the original claimant, with the department or person in charge of the bank. Assigned claims may not be offset against obligations due the bank. A check or draft drawn against a bank closed or taken possession of by the department, whether issued before or after closing, may not be recognized as a claim against the bank or as an assignment of any amount, whether protested or not protested.

History: En. Sec. 135, Ch. 89, L. 1927; re-en. Sec. 6014.145, R.C.M. 1935; amd. Sec. 5, Ch. 145, L. 1931; amd. Sec. 57, Ch. 431, L. 1975; amd. Sec. 25, Ch. 71, L. 1977; R.C.M. 1947, 5-1115; amd. Sec. 1018, Ch. 56, L. 2009.

Cross-References

Powers of receivers, 27-20-302.
Assignments for benefit of creditors, Title 31, ch. 2, part 2.
Escheat, 70-1-203.

32-1-536. Deposit of funds in department's hands. All funds in the hands of the department belonging to a bank in process of liquidation shall be deposited in the department's name in those banks within the state which may be selected and designated by it and subject to its checks. Those funds are to be preferred and protected as provided in this chapter.

History: En. Sec. 136, Ch. 89, L. 1927; re-en. Sec. 6014.146, R.C.M. 1935; amd. Sec. 58, Ch. 431, L. 1975; R.C.M. 1947, 5-1116.

Cross-References

Investments of financial institutions, 32-1-424.

32-1-537. Disposition of unclaimed funds. (1) The department shall certify to the state treasurer a complete list of funds remaining with it that are uncalled for and that have been left with it in its official capacity in trust for depositors in and creditors of a liquidated bank after they have been held by it for 6 months from the date of the final liquidation of the institution. Along with this certificate, the department shall transmit to the state treasurer the funds, with accumulated interest on them, that it has held in trust for 6 months. A copy of the certificate must also be filed with the state auditor, who shall make a record of it.

(2) The state treasurer shall deposit the funds and interest in the general fund.

(3) A depositor or creditor of a liquidated bank who has not been paid the amount standing to the person's credit as certified to the state treasurer may apply to the department for the amount due. The depositor or creditor shall make an affidavit and offer proof of identity and of the amount due. When satisfied as to the correctness of the claim and of the identity of the person, the department shall forward it to the state treasurer who shall audit the claim and, if found correct, certify the claim to the department. If the department approves the claim, it shall pay the claim to the depositor or creditor.

History: En. Sec. 137, Ch. 89, L. 1927; re-en. Sec. 4016.147, R.C.M. 1935; amd. Sec. 1, Ch. 143, L. 1961; amd. Sec. 59, Ch. 431, L. 1975; amd. Sec. 2, Ch. 343, L. 1977; R.C.M. 1947, 5-1117; amd. Sec. 43, Ch. 395, L. 1993; amd. Sec. 27, Ch. 325, L. 1995; amd. Sec. 33, Ch. 422, L. 1997.

Cross-References

State finance — fund structure, 17-2-102.
Deposit of funds in hands of State Treasurer, 17-6-101.

32-1-538. Disposition of assets remaining after payment of claims. (1) Except as provided in subsection (4), when the department has paid to each depositor and creditor of the bank whose claims have been approved and allowed as provided in this chapter the amount due on them or made satisfactory adjustment of them and has made provisions for unclaimed and unpaid deposits and disputed claims and deposits and has paid all the expenses of liquidation, it shall file a report of its administration of the trust with the clerk of the district court of the county in which the bank is located. If there are remaining assets on hand, the department may apply to the judge of that court for an order authorizing it to surrender the remaining assets, together with all the stationery, correspondence, books, and records kept by the bank while it was a going concern, to the directors of the bank in office at the time of closing it, as trustees for stockholders, or to some other person, if any, designated as trustee by a majority of the stockholders. The report and petition must be set for hearing upon notice that the court may direct. Upon hearing and approval of the report and account and the surrender of the assets as directed, the department is discharged from all further liability or responsibility in connection with the assets and affairs of the bank. The court may, if requested, require the trustees to give bond in an amount the court may fix, conditioned for the faithful performance of their duties. The trustee or trustees shall complete the liquidation of any remaining assets and may sell and dispose of real and personal property as rapidly as possible and shall distribute the proceeds among the stockholders as their rights may appear or dispose of the proceeds in some other manner as the stockholders by majority action direct. The court may upon request of a majority of the stockholders order the department to close up the trust as provided in subsection (2).

(2) If the assets of the bank are insufficient for making payments in full to the depositors and creditors of the bank, then, when the department has liquidated all available assets and disbursed them as provided by law, the department shall file a final report of its liquidation of the bank with the clerk of court of the county in which the bank is located. Upon notice that the court may order, the report must be set for hearing before the court and, if found correct and all funds accounted for, the court shall approve it. The department may at the same time and in the report make application to the district court of the county in which the bank is located for an order directing the closing of the trust, and upon entry of the order closing the trust, the department is discharged from all further liability or responsibility in connection with the assets and affairs of the bank. The charter of the bank must be forfeited and all the stationery, correspondence, books, and records kept by the bank while it was a going concern and considered by the department to be of no value may be destroyed. However, correspondence or records may not be destroyed until 10 years after the date the bank ceased to be a going concern.

(3) On application for orders as provided in this section, the bank must be made a party by notice issued on order of the court or judge and served in a manner the court directs and applications authorized by this section may be heard at any time upon not less than 5 days' posted or served notice of the hearing.

(4) If the federal deposit insurance corporation is appointed as the liquidating agent, the reporting and district court approval requirements of subsections (1) through (3) do not apply.

History: En. Sec. 138, Ch. 89, L. 1927; amd. Sec. 1, Ch. 78, L. 1935; re-en. Sec. 6014.148, R.C.M. 1935; amd. Sec. 60, Ch. 431, L. 1975; R.C.M. 1947, 5-1118; amd. Sec. 44, Ch. 395, L. 1993.

Cross-References

Examination and supervision by Department, 32-1-211.
Destruction of bank records, 32-1-491.
Modification and termination of trusts, Title 72, ch. 38, part 4.

32-1-539 through 32-1-550 reserved.

32-1-551. Liquidating officer's powers and duties. (1) Except as provided in subsection (3), after taking possession of a bank for the purpose of liquidation, the liquidating officer may as soon as the officer ascertains that the assets of the bank will be insufficient to pay its debts and liabilities, proceed to collect and enforce the stockholders' liability. For that purpose, the officer may institute and maintain in the officer's own name as liquidating officer appropriate suits or actions in any state or federal court of competent jurisdiction. The liquidating officer may receive and receipt for money received on account of stockholders' liability, and any money paid to the liquidating officer by a stockholder in whole or partial satisfaction of the stockholder's liability is not considered paid voluntarily but gives the stockholder the same protection to the extent of the amount paid as if the payments were made after suit by a creditor or the liquidating officer. The liquidating officer may, with the consent of the court having jurisdiction of the liquidation, compromise, settle, and compound claims for stockholders' liability, and the settlements and compromises when approved by the court are legal and binding upon all parties concerned, including creditors.

(2) (a) Except as provided in subsection (2)(b), all sums collected by a liquidating officer on account of stockholders' liability, either received from voluntary payments or collected by

suits, settlements, or compromises, must be distributed to the creditors of the bank according to their several rights in the same proportion as the amount of a given claim of a creditor bears to the amount of the claims of all creditors and without regard to the rank or class or character of claims and without diminution.

(b) The liquidating officer may deduct from amounts collected the court costs or attorney fees (the attorney fees to be allowed for not more than 10% of the amount collected, provided that the 10% allowed for attorney fees may not apply to collections that are made outside of the state of Montana) and other expenses incurred by the officer in the prosecution of any action for collection.

(3) If the federal deposit insurance corporation is appointed as the liquidating agent, the reporting and district court approval requirements of subsections (1) and (2) do not apply.

History: En. as part of Sec. 21, Ch. 89, L. 1927; amd. Sec. 1, Ch. 110, L. 1935; re-en. Sec. 6014.25, R.C.M. 1935; R.C.M. 1947, 5-402; amd. Sec. 45, Ch. 395, L. 1993.

Cross-References

Attorney fees, Title 25, ch. 10, part 3.
Officers' fees — prepayment, Title 25, ch. 10, part 4.
Powers of receiver, 27-20-302.

32-1-552. Further duties of liquidating officer. (1) For the purpose of this section the term "liquidating officer" includes every person legally empowered to liquidate the business and affairs of a state bank, whether the liquidation is by the department or its deputies and agents. The term also includes all receivers of state banks qualified to liquidate a state bank under any law of this state.

(2) The liquidating officer of a bank may decide when the assets of a failed bank are not sufficient to pay the debts, contracts, engagements, and liabilities and may determine the time when and the court where necessary legal proceedings are conducted, subject to the general provisions of law governing venue and place of trial.

(3) The provisions of 32-1-551 through 32-1-553 do not impose liability on a stockholder of a bank that is a member of the federal deposit insurance corporation.

History: En. as part of Sec. 21, Ch. 89, L. 1927; amd. Sec. 1, Ch. 110, L. 1935; re-en. Sec. 6014.25, R.C.M. 1935; amd. Sec. 11, Ch. 431, L. 1975; amd. Sec. 3, Ch. 71, L. 1977; R.C.M. 1947, 5-403(1) thru (3); amd. Sec. 46, Ch. 395, L. 1993.

Cross-References

Venue, Title 25, ch. 2.
Powers of receiver, 27-20-302.
Federal Deposit Insurance Corporation, Title 32, ch. 1, part 6.

32-1-553. Department to file inventory — report required — exception. (1) Except as provided in subsection (2), the department shall, within 90 days after taking charge of an insolvent bank, file with the district court having jurisdiction a complete inventory of all of the property and assets of the insolvent bank, such as furniture, fixtures, real estate, mortgages, bonds, and notes, secured and unsecured. The department shall every 6 months, or more often if required by the court, file with the court a report showing the status of the liquidation of the bank, the assets that have been liquidated and collected, the amounts and manner of payments made to creditors, the manner in which claims have been handled, and the assets on hand. The report must contain other information the court requires, so that the court and the public may be apprised of the condition of the bank and the manner in which it is being liquidated with respect to the collection and sale of assets belonging to the bank and the manner in which claims are being paid. The report and account must be set for hearing upon the notice the court may require and, if found to be correct, be approved by the court.

(2) If the federal deposit insurance corporation is appointed as the liquidating agent, subsection (1) does not apply.

History: En. as part of Sec. 21, Ch. 89, L. 1927; amd. Sec. 1, Ch. 110, L. 1935; re-en. Sec. 6014.25, R.C.M. 1935; amd. Sec. 11, Ch. 431, L. 1975; amd. Sec. 3, Ch. 71, L. 1977; R.C.M. 1947, 5-403(4); amd. Sec. 47, Ch. 395, L. 1993.

Cross-References

Assignments for benefit of creditors — inventory required, 31-2-213.
Purchase of obligation of bank by officer, 32-1-466.

32-1-554 through 32-1-560 reserved.

32-1-561. Definitions. As used in 32-1-562 through 32-1-565, unless the context requires otherwise, the following definitions apply:

(1) "Bank" includes commercial banks, savings banks, trust companies, any person or association of persons lawfully carrying on the business of banking, whether incorporated or not, and, to the extent that the provisions of 32-1-562 through 32-1-565 are not inconsistent with and do not infringe on paramount federal law, also includes national banks.

(2) "Emergency" means any condition or occurrence which may interfere physically with the conduct of normal business operations at any of the offices of a bank or which poses an imminent or existing threat to the safety or security of persons or property or both. Without limiting the generality of the foregoing, an emergency may arise as a result of any of the following:

(a) fire;
(b) flood;
(c) earthquake;
(d) hurricanes;
(e) wind, rain, or snowstorms;
(f) labor disputes and strikes;
(g) power failures;
(h) transportation failures;
(i) interruption of communication or internet facilities;
(j) shortages of fuel, housing, food, transportation, or labor;
(k) robbery or attempted robbery;
(l) actual or threatened enemy attack;
(m) epidemics or other catastrophes;
(n) riots, civil commotions, and other acts of lawlessness or violence, actual or threatened;
(o) cyberattacks or ransomware attacks.

(3) "Office" means any place at which a bank transacts its business or conducts operations related to its business.

(4) "Officer" means the person or persons designated by the board of directors, board of trustees, or other governing body of a bank to act for the bank in carrying out the provisions of 32-1-562 through 32-1-565 or, in the absence of a designation or of the officer or officers designated, the president or any other officer currently in charge of the bank or of the office or offices involved.

History: En. Sec. 1, Ch. 32, L. 1971; amd. Sec. 38, Ch. 431, L. 1975; R.C.M. 1947, 5-1058; amd. Sec. 25, Ch. 23, L. 2023.

Cross-References

Disaster and emergency services, Title 10, ch. 3.
Bank holidays, 32-1-481.
Robbery, 45-5-401.
Theft, 45-6-301.
Riot, 45-8-103.

32-1-562. Power of department. When the department is of the opinion that an emergency exists or is impending in this state or in any part of this state, it may, by proclamation, authorize banks located in the affected area to close any of their offices. In addition, if the department is of the opinion that an emergency exists or is impending which affects or may affect a particular bank or banks, or a particular office or offices thereof, but not banks located in the area generally, it may authorize the particular bank or banks or office or offices so affected to close. The office or offices so closed shall remain closed until the department proclaims that the emergency has ended or until such earlier time as the officers of the bank determine that one or more offices theretofore closed because of the emergency should reopen and, in either event, for such further time thereafter as may reasonably be required to reopen.

History: En. Sec. 2, Ch. 32, L. 1971; amd. Sec. 39, Ch. 431, L. 1975; R.C.M. 1947, 5-1059.

32-1-563. Powers of officers. (1) When the officers of a bank are of the opinion that an emergency exists or is impending that affects or may affect any of a bank's offices, they may, in the reasonable and proper exercise of their discretion, determine to not open any of those offices on any banking day or, if having opened, to close any of those offices during the continuation of the emergency, even if the department has not issued and does not issue a proclamation of emergency. An office closed as such must remain closed until the officers determine that the emergency has ended and for a further time thereafter as may reasonably be required to reopen.

(2) The officers of a bank may close any of the bank's offices on any day:

(a) designated by proclamation of the president of the United States or the governor of this state as a day of mourning, rejoicing, or other special observance;

(b) that the federal reserve bank of Minneapolis is not open for business; or

(c) with the permission of the department to commemorate or memorialize a special day, event, or individual.

History: **En. Sec. 3, Ch. 32, L. 1971; amd. Sec. 40, Ch. 431, L. 1975; R.C.M. 1947, 5-1060; amd. Sec. 2, Ch. 264, L. 1979; amd. Sec. 26, Ch. 23, L. 2023.**

Cross-References

Powers and duties of Governor, 2-15-201.

Selection of officers and employees — meetings and minutes, 32-1-325.

Bank holidays, 32-1-481.

32-1-564. Notice of bank closing. (1) A bank closing an office under authority granted under 32-1-563(1) shall give to the department as prompt notice of its action as conditions will permit and by any means available, and, in the case of a national bank, to the comptroller of the currency. The bank shall estimate the time the office will remain closed and notify the department when the office reopens.

(2) A bank that is unable to provide services by any means, including mobile applications, automatic teller machines, online or telephone transactions, or services at any mobile or temporary branch, shall immediately notify the department.

History: **En. Sec. 4, Ch. 32, L. 1971; amd. Sec. 41, Ch. 431, L. 1975; R.C.M. 1947, 5-1061; amd. Sec. 27, Ch. 23, L. 2023.**

Cross-References

National bank powers extended to state banks, 32-1-362.

Bank holidays, 32-1-481.

32-1-565. Effect of closing. (1) A day on which a bank or any of its offices is closed during any part of its normal banking hours under 32-1-562 and 32-1-563 with respect to that bank or, if not all of its offices are closed, then with respect to the office or offices which are closed shall be a legal holiday for all purposes with respect to any banking business. No liability or loss of rights of any kind on the part of a bank, or director, officer, or employee thereof, may accrue or result by virtue of a closing authorized by 32-1-562 and 32-1-563.

(2) The provisions of 32-1-561 through 32-1-565 are in addition to any other law of this state or of the United States authorizing the closing of a bank or excusing the delay by a bank in the performance of its duties and obligations because of emergencies or conditions beyond the bank's control or otherwise.

History: **En. Sec. 5, Ch. 32, L. 1971; amd. Sec. 42, Ch. 431, L. 1975; R.C.M. 1947, 5-1062.**

Cross-References

Bank holidays, 32-1-481.

Transactions on holidays, 32-1-482.

Part 6
Federal Deposit Insurance Corporation

Part Cross-References

Insurance on deposits of public funds, 17-6-102.

32-1-601. Definition of banking institution. The term "banking institution" as used in this part shall be construed to mean any bank, trust company, bank and trust company, stock savings bank, or mutual savings bank, which is now or may hereafter be organized under the laws of this state.

History: **En. Sec. 1, Ch. 197, L. 1937; R.C.M. 1947, 5-1201.**

Cross-References

Institutions to which chapter is applicable, 32-1-102.

32-1-602. Banking institutions empowered to receive federal deposit insurance corporation aid. A banking institution may, on the authority of its board of directors or a majority thereof, enter into those contracts, incur those obligations, and generally perform any acts necessary or appropriate in order to take advantage of any memberships, loans, subscriptions, contracts, grants, rights, or privileges available to banking institutions or to their depositors, creditors, stockholders, conservators, or liquidators by virtue of those provisions of the Federal Deposit Insurance Act which establish the federal deposit insurance corporation and provide for the insurance of deposits or of any other act or resolution of congress to aid, regulate, or safeguard banking institutions and their depositors. A banking institution may also subscribe for and acquire stock, debentures, bonds, or other types of securities of the federal deposit insurance corporation and may comply with the lawful rules and requirements from time to time adopted by that corporation.

History: **En. Sec. 2, Ch. 197, L. 1937; amd. Sec. 64, Ch. 431, L. 1975; R.C.M. 1947, 5-1202.**

Cross-References

Board of directors — qualifications, tenure, and vacancies, 32-1-322.
Investments of financial institutions, 32-1-424.

32-1-603. Appointment of the corporation as agent in liquidation. If a banking institution, the deposits in which are in any extent insured by the federal deposit insurance corporation created by the Federal Deposit Insurance Act, 12 U.S.C. 1811 through 1831, is closed on account of inability to meet the demands of its creditors, the department may appoint the corporation agent, without bond, to assist it or act for it in the liquidation of that banking institution.

History: **En. Sec. 3, Ch. 197, L. 1937; amd. Sec. 65, Ch. 431, L. 1975; R.C.M. 1947, 5-1203.**

Cross-References

Powers of Department on closing bank — court proceedings, 32-1-515.
Further duties of liquidating officer, 32-1-552.

32-1-604. Subrogation of corporation. Whenever any banking institution shall have been closed as aforesaid and said federal deposit insurance corporation shall pay or make available for payment the insured deposit liabilities of such closed institution, said corporation, whether or not it shall have been appointed agent of the department in the liquidation of such closed banking institution, as herein provided, shall be and become subrogated by operation of law to all rights against such closed banking institution of each owner of a claim for deposit to the extent now or hereafter necessary to enable the federal deposit insurance corporation, under federal law, to make insurance payments available to depositors of closed insured banks.

History: **En. Sec. 4, Ch. 197, L. 1937; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-1204.**

Cross-References

Payment of claims, 32-1-533.

32-1-605. Examinations by the corporation — accepted when. (1) The department may accept, in its discretion, in place of any examination authorized by the laws of this state to be conducted by the department of a banking institution, the examination made of it within a reasonable period by the federal deposit insurance corporation, if a signed copy of the examination is furnished to the department. The department may also, in its discretion, accept a report relative to the condition of a banking institution obtained by the corporation within a reasonable period, in place of a report authorized by the laws of this state to be required of the institution by the department, if a copy of the report is furnished to the department. The department may, in its discretion, disclose to the corporation, or an official or examiner thereof, any information possessed by the department with reference to the conditions or affairs of an insured institution.

(2) The department may furnish to the corporation, or to an official or examiner thereof, a copy or copies of any examinations made of those banking institutions and of any reports made by them.

(3) Nothing in this section limits the duty of any banking institution in this state, deposits in which are to any extent insured under the Federal Deposit Insurance Act or any substitution for it, to comply with the provisions of that act, its substitutions, or the requirements of that corporation relative to examinations and reports or limits the powers of the department with reference to examinations and reports under existing law.

History: **En. Sec. 5, Ch. 197, L. 1937; amd. Sec. 66, Ch. 431, L. 1975; R.C.M. 1947, 5-1205.**

Cross-References

Examination and supervision by Department, 32-1-211.
Special examination defined, 32-1-214.
Special examinations and fees, 32-1-215.
Examination at request of directors, 32-1-216.

32-1-606. Closed banking institutions empowered to borrow from corporation. If a banking institution is closed on account of inability to meet the demands of its depositors, by action of the department, by action of its directors, or in the event of its insolvency or suspension, the department or its agent may borrow from the corporation and furnish any of the assets of the institution to the corporation as security for a loan from the corporation. The department may sell to the corporation any part or all of the assets of the institution. The provisions of this section do not limit the power of a banking institution or the department to pledge or sell assets in accordance with any existing law.

History: En. Sec. 6, Ch. 197, L. 1937; amd. Sec. 67, Ch. 431, L. 1975; R.C.M. 1947, 5-1206; amd. Sec. 48, Ch. 395, L. 1993.

Cross-References

Purchase of obligation of bank by officer, 32-1-466.

Power of closed banks to borrow money from governmental agencies, 32-1-507.

Part 7
Uniform Common Trust Act

Part Cross-References

Trust Code, Title 72, ch. 38.

32-1-701. Short title. This part may be cited as the "Uniform Common Trust Act".

History: En. Sec. 4, Ch. 64, L. 1955; R.C.M. 1947, 5-1404.

32-1-702. Application. This part shall apply to fiduciary relationships in existence as of July 1, 1955, or thereafter established.

History: En. Sec. 7, Ch. 64, L. 1955; R.C.M. 1947, 5-1406.

Cross-References

Agency, Title 28, ch. 10.

Estates, Trusts, and Fiduciary Relationships, Title 72.

32-1-703. Common trust fund allowed. (1) Any bank or trust company qualified to act as fiduciary in this state may establish and administer common trust funds composed of property permitted by law for the investment of trust funds for the purpose of furnishing investments to:

(a) itself as fiduciary;

(b) itself and others as cofiduciaries;

(c) any affiliated bank or trust company, including any foreign affiliated bank or trust company, as fiduciary;

(d) any affiliated bank or trust company, including any foreign affiliated bank or trust company, and others as cofiduciaries; or

(e) any combination of the entities listed in subsections (1)(a) through (1)(d).

(2) Any bank or trust company may, as that fiduciary or cofiduciary, invest funds which it lawfully holds for investment in interests in the common trust funds administered by itself or by any affiliated bank or trust company if the investment is not prohibited by the instrument, judgment, decree, order, or statute creating and governing such fiduciary relationship and if, in the case of cofiduciaries, the bank or trust company procures the consent of its cofiduciaries to the investment.

History: En. Sec. 1, Ch. 64, L. 1955; amd. Sec. 68, Ch. 431, L. 1975; R.C.M. 1947, 5-1401; amd. Sec. 1, Ch. 213, L. 1981.

Cross-References

Banks allowed to join federal reserve bank, 32-1-373.

Investments of financial institutions, 32-1-424.

Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31, part 1.

Trust Code, Title 72, ch. 38.

32-1-704. Accounting for trust funds. Unless ordered by a court of competent jurisdiction, the bank or trust company operating such common trust funds is not required to render a court accounting with regard to such funds, but it may, by application to the district court, secure approval of such an accounting on such conditions as the court may establish.

History: En. Sec. 2, Ch. 64, L. 1955; R.C.M. 1947, 5-1402.

32-1-705. Construction. This part shall be so interpreted and construed as to effectuate its general purpose to make uniform the law of those states which enact it.

History: En. Sec. 3, Ch. 64, L. 1955; R.C.M. 1947, 5-1403.

32-1-706. Common trust funds established. Each common trust fund established hereunder is a separate and distinct entity from the fiduciary relationships participating in the fund. No fiduciary, in administering a participating fiduciary relationship, may be required to make any apportionment or allocation between the principal and income of such relationship different from that made for the common trust fund. No such participating fiduciary relationship or person having an interest in the relationship may have or be considered to have any ownership in any particular property of the common trust fund; but each participating fiduciary relationship shall have a proportionate undivided interest in the fund and its income; and the ownership of all property of the common trust fund shall be in the trustee of the fund.

History: En. 5-1407 by Sec. 1, Ch. 271, L. 1977; R.C.M. 1947, 5-1407; amd. Sec. 2, Ch. 213, L. 1981.

Cross-References

Consolidation or merger of banks, 32-1-371.

Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31, part 1.

32-1-707. Affiliated defined. For purposes of this part, two or more banks or trust companies are affiliated if they are members of the same affiliated group, within the meaning of section 1504 of the United States Internal Revenue Code.

History: En. Sec. 3, Ch. 213, L. 1981.

32-1-708. Limited application of insurance law — exemption. (1) Nothing in this part exempts a common trust fund or any fiduciary thereof from the requirements of Title 33 if such common trust fund or fiduciary is used for insurance purposes.

(2) The establishment and maintenance of common trust funds under this part are exempt from the provisions of Title 30, chapter 10.

History: En. Sec. 4, Ch. 213, L. 1981.

Part 8
Subsidiary Trust Companies
(Repealed)

32-1-801. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1501 by Sec. 1, Ch. 401, L. 1975; R.C.M. 1947, 5-1501.

32-1-802. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1502 by Sec. 2, Ch. 401, L. 1975; R.C.M. 1947, 5-1502.

32-1-803. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1503 by Sec. 3, Ch. 401, L. 1975; R.C.M. 1947, 5-1503; amd. Sec. 78, Ch. 370, L. 1987; amd. Sec. 2, Ch. 24, L. 1989; amd. Sec. 49, Ch. 395, L. 1993.

32-1-804. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1504 by Sec. 4, Ch. 401, L. 1975; R.C.M. 1947, 5-1504.

32-1-805. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1505 by Sec. 5, Ch. 401, L. 1975; R.C.M. 1947, 5-1505.

32-1-806. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1506 by Sec. 6, Ch. 401, L. 1975; R.C.M. 1947, 5-1506.

32-1-807. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1507 by Sec. 7, Ch. 401, L. 1975; R.C.M. 1947, 5-1507; amd. Sec. 1019, Ch. 56, L. 2009.

32-1-808. Repealed. Sec. 28, Ch. 23, L. 2023.

History: En. 5-1508 by Sec. 8, Ch. 401, L. 1975; amd. Sec. 27, Ch. 71, L. 1977; R.C.M. 1947, 5-1508; amd. Sec. 1020, Ch. 56, L. 2009.

Part 9
Removal of Directors or Officers of Financial Institutions

Part Cross-References

Theft, 45-6-301.

Issuing bad check, 45-6-316.

Deceptive practices, 45-6-317.

Deceptive business practices, 45-6-318.

32-1-901. Definitions. For purposes of this part, the following definitions shall apply:

(1) "Board member" means a member of the board of directors of the institution.

(2) "Cease and desist order which has become final" and "order which has become final" mean a cease and desist order or an order issued by the director with the consent of the institution or the board member, officer, or other person concerned, with respect to which:

(a) a timely petition for review of the action of the director has not been filed in a district court as specified in 32-1-908(2); or

(b) the action of the court in which a petition for review has been filed is not subject to further review by the courts of the state.

(3) "Director" means the director of the department of administration.

(4) "Institution" means a commercial bank, savings bank, trust company, or investment company chartered under Title 32, chapter 1.

(5) "Violation" includes without limitation any action, alone or with others, causing, counseling, aiding, or abetting a violation.

History: En. Sec. 1, Ch. 76, L. 1979; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 79, Ch. 483, L. 2001.

32-1-902. Notice of charges — hearing — cease and desist order — effective date. (1) If the director has reasonable cause to believe that any institution is engaging or has engaged or is about to engage in an unsafe or unsound practice in conducting the business of such institution or is violating, has violated, or is about to violate a law or rule, the director may issue and serve upon the institution a notice of charges in respect thereof. The notice shall contain a statement of the facts constituting the alleged unsafe or unsound practice or violation and shall fix a time and place at which a hearing will be held to determine whether an order to cease and desist therefrom should issue against the institution.

(2) The hearing may not be earlier than 30 days or later than 60 days after service of the notice unless an earlier or a later date is set by the director at the request of the institution. Unless the institution appears at the hearing by a duly authorized representative, it shall be considered to have consented to the issuance of the cease and desist order. In the event of such consent or if upon the record made at any such hearing the director finds that any unsafe or unsound practice or violation specified in the notice of charges has been established by the preponderance of the evidence, the director may issue and serve upon the institution an order to cease and desist from any such practice or violation. By provisions which may be mandatory or otherwise, the order may require the institution and its board members, officers, employees, and agents to cease and desist from such practice or violation and to take affirmative action to correct the conditions resulting from any such practice or violation.

(3) A cease and desist order becomes effective at the expiration of 45 days after the service of the order upon the institution, except in the case of an order issued upon consent which is effective at the time specified therein, and remains effective and enforceable as provided therein, except to the extent it is stayed, modified, terminated, or set aside by the action of the director or a reviewing court.

History: En. Sec. 2, Ch. 76, L. 1979.

Cross-References

Contested cases — notice, 2-4-601.
Sale of securities by officer to bank, 32-1-463.
Fraud by director, officer, or employee, 32-1-464.
Overdraft by officer or employee — receiving personal profit from loan, 32-1-465.
Purchase of obligation of bank by officer, 32-1-466.
Loans to managing officer or director, 32-1-467.
Removal of directors, officers, or employees, 32-1-468.
Penalty for unlawful hypothecation of property, 32-1-471.
Theft of bank funds by officers or employees, 32-1-473.

32-1-903. Informal conferences — time for application. Within 15 days after service of the notice of charges, either the institution or department may request an informal conference to discuss the charges and the possible disposition of the charges without a formal hearing process. The conference must be carried out in accordance with the provisions of 2-4-603. Upon a proper showing, the director may withdraw charges and proceedings for a cease and desist order.

History: En. Sec. 3, Ch. 76, L. 1979; amd. Sec. 1021, Ch. 56, L. 2009.

Cross-References

Examination and supervision by Department, 32-1-211.

32-1-904. Temporary cease and desist order — grounds for issuance — effective date — injunctive relief. (1) Whenever the director determines that any violation or threatened violation or any unsafe or unsound practice specified in the notice of charges served upon the institution pursuant to 32-1-902(1) or the continuation thereof is likely to cause insolvency or substantial dissipation of assets or earnings of the institution or is likely to otherwise seriously prejudice the interests of its depositors, the director may issue a temporary order requiring the institution to cease and desist from the violation or practice. The order must contain a statement of the facts constituting the alleged violation or unsafe or unsound practice. The order is effective upon service of the order upon the institution and unless set aside, limited, or suspended by a court in proceedings authorized by subsection (2) remains effective and enforceable until the completion of the administrative proceedings pursuant to the notice of charges, until the director dismisses the charges specified in the notice, or until a cease and desist order that is issued against the institution after the hearing becomes effective.

(2) Within 14 days after the institution has been served with a temporary cease and desist order, the institution may apply to the district court for the county in which the home office of the institution is located for an injunction setting aside, limiting, or suspending the enforcement, operation, or effectiveness of the order pending the completion of the administrative proceedings held pursuant to the notice of charges served upon the institution under 32-1-902(1). The court has jurisdiction to issue the injunction.

History: **En. Sec. 4, Ch. 76, L. 1979; amd. Sec. 11, Ch. 49, L. 2013.**

Cross-References

Injunctions, Title 27, ch. 19.

32-1-905. Notice of intention to remove board member or officer or to prohibit participation — suspension. (1) The director may serve upon a board member or officer of an institution a written notice of intention to remove the member or officer from office whenever the director has reasonable cause to believe that:

(a) the board member or officer has:

(i) committed any violation of law involving dishonesty or breach of trust;

(ii) violated a cease and desist order that has become final;

(iii) engaged or participated in any unsafe or unsound practice in connection with the institution; or

(iv) committed or engaged in any act, omission, or practice that constitutes a breach of the member's or officer's fiduciary duty as a board member or officer of the institution; and

(b) the institution has suffered or will probably suffer substantial financial loss or other damage or the interest of its depositors could be seriously prejudiced by reason of the violation, practice, or breach of fiduciary duty involving personal dishonesty on the part of the board member or officer.

(2) Whenever in the opinion of the director any board member or officer of an institution has, by conduct or practice with respect to another institution or business organization that has resulted in substantial financial loss or other damage to that institution or business organization, evidenced the member's or officer's personal disability and unfitness to continue as a board member or officer of the institution and whenever the director has reasonable cause to believe that any other person participating in the conduct of the affairs of an institution has, by conduct or practice with respect to the institution, another institution, or other business organization that has resulted in substantial financial loss or other damage to the institution or business organization, evidenced the person's personal disability and unfitness to participate in the conduct of the affairs of the institution, the director may serve upon the board member, officer, or other person a written notice of intention to remove the person from office or to prohibit the person's further participation in any manner in the conduct of the affairs of the institution.

(3) A notice of intention to remove a board member, officer, or other person from office or to prohibit the member's, officer's, or person's participation in the conduct of the affairs of an institution must contain a statement of the facts constituting grounds for the removal or prohibition and must fix a time and place at which a hearing will be held on the removal or

prohibition. The hearing must be held not earlier than 30 days or later than 60 days after the date of service of the notice unless an earlier or later date is set by the director at the request of the board member, officer, or other person and for good cause shown.

(4) Unless the board member, officer, or other person appears at the hearing in person or by a duly authorized representative, the member, officer, or person must be considered to have consented to the issuance of an order of removal or prohibition. In the event of consent or if upon the record made at the hearing the director finds that any of the grounds specified in the notice have been established by the preponderance of the evidence, the director may issue orders of suspension, removal from office, or prohibition from participation in the conduct of the affairs of the institution as the director considers appropriate. The order becomes effective 30 days after service upon the institution and the board member, officer, or other person concerned, except in the case of an order issued upon consent, which becomes effective at the time specified in the order. The order remains effective and enforceable until it is stayed, modified, terminated, or set aside by action of the director or a reviewing court.

History: **En. Sec. 5, Ch. 76, L. 1979; amd. Sec. 1022, Ch. 56, L. 2009.**

Cross-References

False statements and entries considered felony, 32-1-236.
Board of directors — qualifications, tenure, and vacancies, 32-1-322.
Fraud by director, officer, or employee, 32-1-464.
Removal of directors, officers, or employees, 32-1-468.
Theft of bank funds by officers or employees, 32-1-473.
Penalty for receiving deposits when insolvent or for making false statements, 32-1-505.
False swearing, 45-7-202.
Unsworn falsification to authorities, 45-7-203.
Tampering with public records or information, 45-7-208.

32-1-906. Informal conferences — time for application. Within 15 days after service of the notice of charges, either the board member, officer, or other person may request an informal conference to discuss the charges and the possible disposition of the charges without a formal hearing process. The conference must be carried out in accordance with the provisions of 2-4-603. Upon a proper showing, the director may withdraw charges and proceedings for a cease and desist order.

History: **En. Sec. 6, Ch. 76, L. 1979; amd. Sec. 1023, Ch. 56, L. 2009.**

Cross-References

Examination and supervision by Department, 32-1-211.

32-1-907. Suspension or prohibition effective upon service — stay. (1) With respect to any board member or officer of an institution or any other person to whom notice is sent pursuant to 32-1-905, if the director considers it necessary for the protection of the institution or the interests of its depositors that the board member, officer, or other person be suspended from office or prohibited from further participation in any manner in the conduct of the affairs of the institution, the director may serve upon the board member, officer, or other person a written notice suspending the member, officer, or person from office or prohibiting the member, officer, or person from further participation in any manner in the conduct of the affairs of the institution. The notice must contain a statement of the facts constituting grounds for the order and must fix a time, not later than 14 days from the date of the service of the notice, at which a hearing will be held to afford the board member, officer, or other person the opportunity to respond. The suspension or prohibition is effective upon service of the notice and unless stayed by a court in proceedings authorized by subsection (2) remains in effect until the completion of the administrative proceedings pursuant to the notice served under 32-1-904, until the time that the director dismisses the charges specified in the notice, or until the order of removal or prohibition that is issued against the board member, officer, or other person becomes effective. Copies of the notice must also be served upon the institution of which the person is a director or officer or in the conduct of whose affairs the person has participated.

(2) Within 14 days after the hearing provided for in subsection (1), the board member, officer, or other person may apply to the district court for the county in which the home office of the institution is located for a stay of the suspension or prohibition pending the completion of the administrative proceedings pursuant to the notice served upon the board member, officer, or other person under 32-1-904. The court has jurisdiction to stay the suspension or prohibition.

History: **En. Sec. 7, Ch. 76, L. 1979; amd. Sec. 1024, Ch. 56, L. 2009; amd. Sec. 12, Ch. 49, L. 2013.**

Cross-References

District Court jurisdiction, Title 3, ch. 5, part 3.
Removal of directors, officers, or employees, 32-1-468.

32-1-908. Felony charges — suspension or prohibition. (1) Whenever any board member or officer of an institution or other person participating in the conduct of the affairs of an institution is charged in any information, indictment, warrant, or complaint authorized by a county, state, or federal authority with the commission of or participation in a felony involving dishonesty or breach of trust, the director by written notice served upon the board member, officer, or other person may suspend that individual from office or prohibit that individual from further participation in any manner in the conduct of the affairs of the institution. Suspension is effective upon service upon the individual. The notice must contain a statement of the facts constituting grounds for the order and must fix a place and time, not later than 14 days from the date of the notice, at which a hearing will be held to afford the board member, officer, or other person the opportunity to respond. A copy of the notice must also be served upon the institution. The suspension or prohibition remains in effect until the information, indictment, warrant, or complaint is finally disposed of or until terminated by the director.

(2) Within 14 days after the hearing provided for in subsection (1), the board member, officer, or other person may apply to the district court for the county in which the home office of the institution is located for a stay of the suspension or prohibition pending the completion of the criminal proceedings initiated by the information, indictment, warrant, or complaint. The court has jurisdiction to stay the suspension or prohibition.

(3) If a judgment of conviction with respect to the offense is entered against the board member, officer, or other person and at the time that the judgment is not subject to further appellate review, the director may issue and serve upon the board member, officer, or other person an order removing that individual from office or prohibiting that individual from further participation in any manner in the conduct of the affairs of the institution except with the consent of the director. A copy of the order must also be served upon the institution, and upon receipt the board member or officer ceases to be a board member or officer of the institution. A finding of not guilty or other disposition of the charge does not preclude the director from instituting proceedings to suspend or remove the board member, officer, or other person from office or to prohibit further participation in the affairs of the institution pursuant to 32-1-905 or 32-1-906.

History: En. Sec. 8, Ch. 76, L. 1979; amd. Sec. 1025, Ch. 56, L. 2009; amd. Sec. 13, Ch. 49, L. 2013.

Cross-References

Hearing — rules of evidence, cross-examination, and judicial notice, 2-4-612.
False statements and entries considered felony, 32-1-236.
Fraud by director, officer, or employee, 32-1-464.
Removal of directors, officers, or employees, 32-1-468.
Classification of offenses, 45-1-201.
Felony defined, 45-2-101.
Filing of information, Title 46, ch. 11, part 2.

32-1-909. Board of directors — lack of quorum — temporary board members. If at any time because of the suspension or removal of one or more board members pursuant to this part the board of directors of an institution has less than a quorum of board members not so suspended or removed, all powers and functions vested in or exercisable by the board shall vest in and be exercisable by the board members not so suspended or removed until such time as there is a quorum of the board members. If all of the board members have been suspended or removed, the director shall appoint persons to serve temporarily as board members, pending the termination of the suspensions or removals or until such time as their successors are duly elected and take office.

History: En. Sec. 9, Ch. 76, L. 1979.

Cross-References

Board of directors — qualifications, tenure, and vacancies, 32-1-322.

32-1-910. Hearings — decision — review, modification, termination or stay of orders. (1) A hearing provided for in this part must be conducted in accordance with the provisions of the Montana Administrative Procedure Act. The hearing must be private unless the director, after fully considering the views of the party afforded the hearing, determines that a public hearing is necessary to protect the public interest. After the hearing and within 90 days after the director has notified the parties that the case has been submitted for final decision, the director shall render a decision, which must include findings of fact upon which the decision is based, and shall issue and serve upon each party to the proceeding an order consistent with the provisions of this section.

(2) Any party to the hearing or any person required by an order issued under this part to cease and desist from any of the violations or practices stated in the order or any person suspended, removed, or prohibited from participation in the conduct of the affairs of an institution may obtain a review of any order, other than a consent order. The review must be pursuant to the Montana Administrative Procedure Act. Unless a petition for review is timely filed as provided in the Montana Administrative Procedure Act, the director, at any time, upon notice and in a manner that the director considers proper, may modify, terminate, or set aside the order. Upon the timely filing of a petition for review, the director may modify, terminate, or set aside the order with the permission of the court.

History: En. Sec. 10, Ch. 76, L. 1979; amd. Sec. 1026, Ch. 56, L. 2009.

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.
Public participation in governmental operations, Title 2, ch. 3.
Montana Administrative Procedure Act, Title 2, ch. 4.
Judicial review of contested cases, Title 2, ch. 4, part 7.

32-1-911. Notices and orders — manner of service — copies to federal authorities. Any service required or authorized to be made by the director pursuant to this part must be made on individual board members and officers by personal service and may be made on institutions by registered or certified mail or common courier with tracking capability or in any manner reasonably calculated to give actual notice as the director by rule or otherwise may provide. Copies of any notice or order served by the director pursuant to the provisions of this part on any institution or any board member or officer of the institution or other person participating in the conduct of the institution's affairs may also be sent to the appropriate federal supervisory authorities.

History: En. Sec. 13, Ch. 76, L. 1979; amd. Sec. 27, Ch. 75, L. 2019.

Cross-References

Confidentiality — penalties, 32-1-234.

32-1-912. Enforcement of notices or orders. The director may apply to the district court of the county in which the home office of the institution is located or to the district court for Lewis and Clark County if the institution does not have a home office in this state for the enforcement of any effective and outstanding notice or order issued under this part. The court has jurisdiction to require compliance therewith.

History: En. Sec. 11, Ch. 76, L. 1979; amd. Sec. 13, Ch. 535, L. 2021.

Cross-References

District Court jurisdiction, Title 3, ch. 5, part 3.
Judicial remedies defined, 27-1-101.

32-1-913 through 32-1-920 reserved.

32-1-921. Violation of notice or final order — penalties. Any present or former board member or officer of an institution or any other person against whom there is outstanding and effective any notice or final order served upon the board member, officer, or other person pursuant to 32-1-905, 32-1-907, or 32-1-908 who participates in any manner in the conduct of the affairs of such institution; directly or indirectly solicits, procures, transfers, or attempts to transfer votes or attempts to vote any proxies, consents, or authorizations in respect to any voting rights in such institution; or without the prior written approval of the director, votes for a board member or serves as a board member, officer, or employee of such institution is guilty of a misdemeanor and may be fined not more than $1,000 or imprisoned for not more than 6 months, or both.

History: En. Sec. 12, Ch. 76, L. 1979.

Cross-References

Persons previously convicted under banking laws — bank employment, 32-1-462.
Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.

Part 10
Fiduciary Foreign Trust Companies

Part Cross-References

Foreign personal representatives and ancillary administration, Title 72, ch. 4.
Persons under disability — guardianship and conservatorship, Title 72, ch. 5.
Miscellaneous provisions relating to fiduciaries, Title 72, ch. 31.
Trust administration, Title 72, ch. 38.
Trust Code — general provisions, Title 72, ch. 38, part 1.

32-1-1001. Definition of foreign trust company. (1) For the purposes of this part, the term "foreign trust company" includes each banking and trust association or corporation organized under the laws of any state other than Montana that has the power to act as trustee, guardian, or conservator and each national banking association that maintains its principal office in any state other than Montana that has been granted permission by the comptroller of the currency to act in a fiduciary capacity under the provisions of 12 U.S.C. 92a, as amended.

(2) A foreign trust company acting pursuant to this part is not a foreign corporation regulated by 32-1-402.

History: En. Sec. 1, Ch. 290, L. 1993; amd. Sec. 3, Ch. 15, L. 2005.

32-1-1002. Appointment of foreign trust companies. (1) A foreign trust company from a state offering reciprocity, as provided in subsection (2), may accept an appointment and act as:

(a) the trustee of any trust created by will, indenture, or other instrument by a person residing in this state, a corporation with its principal offices in this state, or a political entity located in this state;

(b) a guardian or conservator of the person, estate, or both person and estate of any resident of this state;

(c) an executor of the will or administrator of the estate of a decedent who was a resident of the state in which the foreign trust company maintains its principal office at the time of death, in ancillary probate proceedings in this state; and

(d) a guardian or conservator in ancillary proceedings in this state with respect to the property of a resident of the state in which the foreign trust company maintains its principal office.

(2) A foreign trust company may accept appointments in this state if banking or trust associations or corporations organized under the laws of this state or national banking associations that maintain their principal offices in this state are permitted to act as trustees, guardians, or conservators in the state in which the foreign trust company maintains its principal office.

History: En. Sec. 2, Ch. 290, L. 1993.

32-1-1003. Designation of attorney for service of process. Before accepting an appointment or acting as a trustee, guardian, or conservator, a foreign trust company shall appoint the secretary of state as its attorney for the service of all legal process in any action or proceedings involving any acts or defaults by it as trustee, guardian, or conservator. The appointment is irrevocable. Service upon the secretary of state as attorney is as valid and binding as if personal service were made upon the foreign trust company.

History: En. Sec. 3, Ch. 290, L. 1993.

32-1-1004. Service of process. Service of process under this part may be made by delivering a copy of the papers to be served to the secretary of state personally or by filing a copy in the secretary of state's office, accompanied by one additional copy for each foreign trust company to be served. The secretary of state shall, no later than the business day following the date of service, mail to each served foreign trust company, by certified mail, a copy of papers that were served. The copies must be mailed to the address shown for each foreign trust company in the records of the office of the secretary of state.

History: En. Sec. 4, Ch. 290, L. 1993.

32-1-1005. Bond. Before accepting an appointment or acting as a trustee, guardian, or conservator, a foreign trust company shall file a bond with a court of competent jurisdiction in an amount that the court directs, with sufficient sureties, conditioned on the faithful discharge of its duties as trustee, guardian, or conservator. A foreign trust company is not required to file a bond with respect to a trust, other than a trust created by a will, if the trust instrument requests or directs that a bond is not required of the trustee.

History: **En. Sec. 5, Ch. 290, L. 1993; amd. Sec. 139, Ch. 42, L. 1997; amd. Sec. 80, Ch. 483, L. 2001; amd. Sec. 1, Ch. 122, L. 2013; amd. Sec. 5, Ch. 12, L. 2015.**

32-1-1006. Rights and duties. A foreign trust company acting as trustee, guardian, or conservator has the rights, authority, and duties that a natural person resident in this state duly acting as trustee, guardian, or conservator has under the laws of this state.

History: **En. Sec. 6, Ch. 290, L. 1993.**

32-1-1007. Solicitation of business. A foreign trust company may conduct business in Montana only in accordance with rules adopted by the department.

History: **En. Sec. 7, Ch. 290, L. 1993; amd. Sec. 81, Ch. 483, L. 2001.**

Parts 11 through 14 reserved

Part 15

Financial Institutions — Preventing Financial Exploitation

32-1-1501. Definitions. For the purposes of this part, the following definitions apply:

(1) "Covered agency" means any of the following:

(a) a federal, state, or local law enforcement agency; or

(b) the department of public health and human services as provided in 2-15-2201 or its local affiliate.

(2) "Covered financial institution" means any bank, credit union, savings bank, savings and loan association, or trust company operating in Montana.

(3) "Financial exploitation" means:

(a) the unreasonable use of a vulnerable adult or of a power of attorney, trust, conservatorship, guardianship, or fiduciary relationship with regard to a vulnerable adult in order to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of or interest in the vulnerable adult's money, assets, rights, credit accounts, or property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the vulnerable adult of the ownership, use, benefit, or possession of or interest in the vulnerable adult's money, assets, rights, credit accounts, or property;

(b) an act taken by a person who has the trust and confidence of a vulnerable adult to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of or interest in the vulnerable adult's money, assets, rights, credit accounts, or property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the vulnerable adult of the ownership, use, benefit, or possession of or interest in the vulnerable adult's money, assets, rights, credit accounts, or property; or

(c) the unreasonable use of a vulnerable adult or of a power of attorney, trust, conservatorship, guardianship, or fiduciary relationship with regard to a vulnerable adult done in the course of an offer or sale of insurance or securities in order to obtain control of or to divert to the advantage of another the ownership, use, benefit, or possession of the vulnerable adult's money, assets, rights, credit accounts, or property by means of deception, duress, menace, fraud, undue influence, or intimidation with the intent or result of permanently depriving the vulnerable adult of the ownership, use, benefit, or possession of the person's money, assets, rights, credit accounts, or property.

(4) "Transaction" means any of the following as applicable to services provided by a covered financial institution:

(a) a transfer or request to transfer or disburse funds or assets in an account;

(b) a request to initiate a wire transfer, initiate an automated clearinghouse transfer, or issue a money order, cashier's check, or official check;

(c) a request to negotiate a check or other negotiable instrument;

(d) a request to change the ownership of, or access to, an account;

(e) a request to sell or transfer securities or other assets, or a request to affix a medallion stamp or provide any form of guarantee or endorsement in connection with an attempt to sell or transfer securities or other assets, if the person selling or transferring the securities or assets is not required to register under 30-10-201;

(f) a request for a loan, extension of credit, or draw on a line of credit;

(g) a request to encumber any movable or immovable property; and

(h) a request to designate or change the designation of beneficiaries to receive any property, benefit, or contract right for a vulnerable adult at death.

(5) "Vulnerable adult" has the meaning provided in 52-3-803.

History: En. Sec. 1, Ch. 241, L. 2019; amd. Sec. 2, Ch. 12, L. 2023.

32-1-1502. Notices. (1) A covered financial institution may notify any covered agency if the covered financial institution believes that the financial exploitation of a vulnerable adult is occurring, has or may have occurred, is being attempted, or has been or may have been attempted.

(2) A covered financial institution may notify any third party reasonably associated with a vulnerable adult if the covered financial institution believes that the financial exploitation of a vulnerable adult is occurring, has or may have occurred, is being attempted, or has been or may have been attempted. A third party reasonably associated with a vulnerable adult includes but is not limited to the following:

(a) a parent, spouse, adult child, sibling, or other known family member or close associate of a vulnerable adult;

(b) an authorized contact provided by a vulnerable adult to the covered financial institution;

(c) a co-owner, additional authorized signatory, or beneficiary on a vulnerable adult's account; and

(d) an attorney-in-fact, trustee, conservator, guardian, or other fiduciary who has been selected by the vulnerable adult, a court, a governmental agency, or a third party to manage some or all of the financial affairs of the vulnerable adult.

(3) A covered financial institution may choose not to notify any third party reasonably associated with a vulnerable adult of suspected financial exploitation of the vulnerable adult if the covered financial institution believes the third party is, may be, or may have been engaged in the financial exploitation of the vulnerable adult.

(4) A covered financial institution shall make a reasonable effort, at least annually, to notify the appropriate employees of the covered financial institution of their ability to report potential financial exploitation of a vulnerable adult to personnel within the covered financial institution.

History: En. Sec. 2, Ch. 241, L. 2019; amd. Sec. 3, Ch. 12, L. 2023.

32-1-1503. Delaying transactions. (1) A covered financial institution may, but is not required to, delay completion or execution of a transaction involving an account of a vulnerable adult, an account on which a vulnerable adult is a beneficiary, an account in which the vulnerable adult has a financial interest, or an account of a person suspected of perpetrating financial exploitation if either of the following conditions apply:

(a) the covered financial institution reasonably believes that the requested transaction may result in financial exploitation of a vulnerable adult; or

(b) a covered agency provides information demonstrating to the financial institution that it is reasonable to believe that financial exploitation is occurring, has or may have occurred, is being attempted, or has been or may have been attempted.

(2) If a covered financial institution delays a transaction pursuant to subsection (1), the covered financial institution shall, no later than 2 business days after the transaction is delayed, send written notification of the delay and the reason for the delay to all parties authorized to transact business on the account for which the covered financial institution has contact information unless any party is reasonably believed to have engaged in attempted financial exploitation of the vulnerable adult. The notification described in this subsection may be provided by electronic means.

(3) If a covered financial institution delays a transaction pursuant to subsection (1), the covered financial institution may provide notification of the delay, the reason for the delay, and any additional information about the transaction to any covered agency.

(4) Except as ordered by a court, a covered financial institution is not required to delay a transaction when provided with information by a covered agency alleging that financial exploitation is occurring, has or may have occurred, is being attempted, or has been or may have been attempted but may use its discretion to determine whether to delay a transaction based on the information available to the covered financial institution.

(5) Except as provided in subsection (6), any delay of a transaction as authorized pursuant to this section expires or is terminated when the earliest of either of the following circumstances occur:

(a) the covered financial institution reasonably determines that the transaction will not result in financial exploitation of a vulnerable adult; or

(b) 15 business days pass from the date on which the covered financial institution first initiated the delay of the transaction.

(6) (a) A covered financial institution may extend the delay provided for in subsection (5) upon receiving a request to extend the delay from any covered agency, in which case the delay expires or is terminated no later than 25 business days from the date on which the covered financial institution first initiated the delay of the transaction.

(b) A court of competent jurisdiction may enter an order extending or shortening a delay or providing other relief based on the petition of the covered financial institution, any covered agency, or other interested party.

History: **En. Sec. 3, Ch. 241, L. 2019; amd. Sec. 4, Ch. 12, L. 2023.**

32-1-1504. Immunity. (1) (a) A covered financial institution and its directors, officers, employees, attorneys, accountants, agents, and other representatives have no duty to act pursuant to this part or otherwise to protect a vulnerable adult from financial exploitation by a third person.

(b) A covered financial institution and its directors, officers, employees, attorneys, accountants, agents, and other representatives are immune from all criminal, civil, and administrative liability for not taking action pursuant to this part.

(c) A covered financial institution and its directors, officers, employees, attorneys, accountants, agents, or other representatives who choose to act pursuant to the authority granted in this part are immune from all criminal, civil, and administrative liability for any act taken pursuant to this part unless the act of the financial institution or its representatives was done in bad faith and caused pecuniary loss to a vulnerable adult who was suspected of being a victim of financial exploitation.

(2) The immunity provided for in this section may not extend to any individual in a case when the individual is a principal, a conspirator, or an accessory after the fact to a criminal offense involving the financial exploitation of a vulnerable adult.

History: **En. Sec. 4, Ch. 241, L. 2019; amd. Sec. 5, Ch. 12, L. 2023.**

CHAPTER 2

MUTUAL SAVINGS AND LOAN ASSOCIATIONS

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32-2-1216. Enforcement of notices or orders.
32-2-1217. Violation of notice or final order — penalties.

Chapter Cross-References

Home owners' loan corporation and housing bonds — investments and security, 7-15-4504, 7-15-4505, 17-6-103, 32-1-424, 72-31-102.

Taxation of association, 15-24-801.

Credit Transactions and Relationships, Title 31.

Definition of regulated lender, 31-1-111.

Insurance premium finance companies, Title 33, ch. 14.

Discrimination prohibited in financial transactions, 49-2-305, 49-2-307, 49-3-206.

Montana Uniform Transfers to Minors Act, Title 72, ch. 26.

Part 1
General Provisions
(Repealed)

32-2-101. Repealed. Sec. 136, Ch. 431, L. 2021.

History: Ap. p. Sec. 1, Ch. 57, L. 1927; re-en. Sec. 6355.1, R.C.M. 1935; amd. Sec. 1, Ch. 187, L. 1945; amd. Sec. 1, Ch. 68, L. 1949; amd. Sec. 69, Ch. 431, L. 1975; Sec. 7-101, R.C.M. 1947; Ap. p. Sec. 13, Ch. 57, L. 1927; re-en. Sec. 6355.14, R.C.M. 1935; Sec. 7-115, R.C.M. 1947; R.C.M. 1947, 7-101, 7-115; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 1, Ch. 5, L. 1983; amd. Sec. 82, Ch. 483, L. 2001.

32-2-102. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 27, Ch. 57, L. 1927; amd. Sec. 1, Ch. 10, L. 1931; re-en. Sec. 6355.28, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-129; amd. Sec. 3, Ch. 600, L. 1985.

32-2-103. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 28, Ch. 57, L. 1927; re-en. Sec. 6355.29, R.C.M. 1935; amd. Sec. 1, Ch. 66, L. 1977; R.C.M. 1947, 7-130.

32-2-104. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 34, Ch. 57, L. 1927; re-en. Sec. 6355.35, R.C.M. 1935; amd. Sec. 81, Ch. 431, L. 1975; R.C.M. 1947, 7-136.

32-2-105. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 33, Ch. 57, L. 1927; re-en. Sec. 6355.34, R.C.M. 1935; R.C.M. 1947, 7-135.

32-2-106. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 35, Ch. 57, L. 1927; re-en. Sec. 6355.36, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-137; amd. Sec. 19, Ch. 557, L. 1987.

32-2-107. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 37, Ch. 57, L. 1927; re-en. Sec. 6355.38, R.C.M. 1935; amd. Sec. 83, Ch. 431, L. 1975; amd. Sec. 30, Ch. 71, L. 1977; R.C.M. 1947, 7-139.

32-2-108. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 38, Ch. 57, L. 1927; re-en. Sec. 6355.39, R.C.M. 1935; R.C.M. 1947, 7-140; amd. Sec. 1027, Ch. 56, L. 2009.

32-2-109. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 39, Ch. 57, L. 1927; re-en. Sec. 6399.40, R.C.M. 1935; R.C.M. 1947, 7-141; amd. Sec. 1028, Ch. 56, L. 2009.

32-2-110. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 73, Ch. 89, L. 1927; amd. Sec. 1, Ch. 167, L. 1929; re-en. Sec. 6014.83, R.C.M. 1935; amd. Sec. 1, Ch. 114, L. 1959; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 5-909; amd. Sec. 4, Ch. 600, L. 1985.

32-2-111. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 1, Ch. 558, L. 1981.

Part 2
Organization and Reorganization (Renumbered and Repealed)

32-2-201. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 2, Ch. 57, L. 1927; re-en. Sec. 6355.2, R.C.M. 1935; amd. Sec. 1, Ch. 67, L. 1949; amd. Sec. 28, Ch. 71, L. 1977; R.C.M. 1947, 7-102; amd. Sec. 2, Ch. 5, L. 1983.

32-2-202. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 3, Ch. 57, L. 1927; re-en. Sec. 6355.3, R.C.M. 1935; R.C.M. 1947, 7-103.

32-2-203. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 4, Ch. 57, L. 1927; re-en. Sec. 6355.4, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-104.

32-2-204. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 5, Ch. 57, L. 1927; re-en. Sec. 6355.5, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-105.

32-2-205. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 6, Ch. 57, L. 1927; re-en. Sec. 6355.6, R.C.M. 1935; amd. Sec. 70, Ch. 431, L. 1975; R.C.M. 1947, 7-106; amd. Sec. 3, Ch. 5, L. 1983.

32-2-206. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 7, Ch. 57, L. 1927; re-en. Sec. 6355.7, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-107; (2)En. Sec. 29, Ch. 5, L. 1983.

32-2-207. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 8, Ch. 57, L. 1927; re-en. Sec. 6355.9, R.C.M. 1935; R.C.M. 1947, 7-109; amd. Sec. 4, Ch. 5, L. 1983.

32-2-208. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 9, Ch. 57, L. 1927; re-en. Sec. 6355.10, R.C.M. 1935; R.C.M. 1947, 7-110; amd. Sec. 5, Ch. 5, L. 1983.

32-2-209. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 10, Ch. 57, L. 1927; re-en. Sec. 6355.11, R.C.M. 1935; R.C.M. 1947, 7-111; amd. Sec. 6, Ch. 5, L. 1983; amd. Sec. 1029, Ch. 56, L. 2009.

32-2-210. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 11, Ch. 57, L. 1927; re-en. Sec. 6355.12, R.C.M. 1935; amd. Sec. 29, Ch. 71, L. 1977; R.C.M. 1947, 7-112; amd. Sec. 7, Ch. 5, L. 1983; amd. Sec. 1030, Ch. 56, L. 2009.

32-2-211. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 14, Ch. 57, L. 1927; re-en. Sec. 6355.15, R.C.M. 1935; R.C.M. 1947, 7-116; amd. Sec. 8, Ch. 5, L. 1983.

32-2-212. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 15, Ch. 57, L. 1927; re-en. Sec. 6355.16, R.C.M. 1935; R.C.M. 1947, 7-117; amd. Sec. 9, Ch. 5, L. 1983; amd. Sec. 1031, Ch. 56, L. 2009.

32-2-213 through 32-2-220 reserved.

32-2-221. Renumbered 32-2-261. Code Commissioner, 1983.

32-2-222. Renumbered 32-2-262. Code Commissioner, 1983.

32-2-223. Renumbered 32-2-263. Code Commissioner, 1983.

32-2-224. Renumbered 32-2-264. Code Commissioner, 1983.

32-2-225 through 32-2-230 reserved.

32-2-231. Renumbered 32-2-271. Code Commissioner, 1983.

32-2-232. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 27, Ch. 5, L. 1983; amd. Sec. 1032, Ch. 56, L. 2009.

32-2-233. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 28, Ch. 5, L. 1983; amd. Sec. 1033, Ch. 56, L. 2009.

32-2-234 through 32-2-240 reserved.

32-2-241. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 30, Ch. 5, L. 1983; amd. Sec. 1034, Ch. 56, L. 2009.

32-2-242. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 31, Ch. 5, L. 1983.

32-2-243. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 32, Ch. 5, L. 1983.

32-2-244. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 33, Ch. 5, L. 1983.

32-2-245. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 34, Ch. 5, L. 1983; amd. Sec. 1035, Ch. 56, L. 2009.

32-2-246 through 32-2-250 reserved.

32-2-251. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 35, Ch. 5, L. 1983.

32-2-252. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 36, Ch. 5, L. 1983.

32-2-253. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 37, Ch. 5, L. 1983.

32-2-254. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 38, Ch. 5, L. 1983; amd. Sec. 1036, Ch. 56, L. 2009.

32-2-255. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 39, Ch. 5, L. 1983; amd. Sec. 1037, Ch. 56, L. 2009.

32-2-256. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 40, Ch. 5, L. 1983.

32-2-257. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 41, Ch. 5, L. 1983.

32-2-258 through 32-2-260 reserved.

32-2-261. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 29, Ch. 57, L. 1927; re-en. Sec. 6355.30, R.C.M. 1935; amd. Sec. 80, Ch. 431, L. 1975; R.C.M. 1947, 7-131; amd. Sec. 10, Ch. 5, L. 1983; MCA 1981, 32-2-221; redes. 32-2-261 by Code Commissioner, 1983.

32-2-262. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 30, Ch. 57, L. 1927; re-en. Sec. 6355.31, R.C.M. 1935; R.C.M. 1947, 7-132; Sec. 32-2-222, MCA 1981; redes. 32-2-262 by Code Commissioner, 1983.

32-2-263. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 31, Ch. 57, L. 1927; re-en. Sec. 6355.32, R.C.M. 1935; R.C.M. 1947, 7-133; Sec. 32-2-223, MCA 1981; redes. 32-2-263 by Code Commissioner, 1983.

32-2-264. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 32, Ch. 57, L. 1927; re-en. Sec. 6355.33, R.C.M. 1935; R.C.M. 1947, 7-134; amd. Sec. 11, Ch. 5, L. 1983; MCA 1981, 32-2-224; redes. 32-2-264 by Code Commissioner, 1983.

32-2-265 through 32-2-270 reserved.

32-2-271. Repealed. Sec. 136, Ch. 431, L. 2021.

History: (1), (2)En. as Subd. 22, 7-113, by Sec. 1, Ch. 168, L. 1931; repealed by Sec. 4, Ch. 11, L. 1933; re-en. Sec. 1, Ch. 11, L. 1933; Sec. 7-113(22), R.C.M. 1947; amd. and redes. 7-113.2 by Sec. 73, Ch. 431, L. 1975; amd. Sec. 1, Ch. 363, L. 1977; Sec. 7-113.2, R.C.M. 1947; (3)En. 7-113.3 by Sec. 2, Ch. 363, L. 1977; Sec. 7-113.3, R.C.M. 1947; R.C.M. 1947, 7-113.2, 7-113.3; amd. Sec. 12, Ch. 5, L. 1983; MCA 1981, 32-2-231; redes. 32-2-271 by Code Commissioner, 1983.

Part 3
Department Responsibility
(Repealed)

32-2-301. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 23, Ch. 57, L. 1927; re-en. Sec. 6355.24, R.C.M. 1935; amd. Sec. 1, Ch. 81, L. 1955; amd. Sec. 77, Ch. 431, L. 1975; R.C.M. 1947, 7-125; amd. Sec. 13, Ch. 5, L. 1983.

32-2-302. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 24, Ch. 57, L. 1927; re-en. Sec. 6355.25, R.C.M. 1935; amd. Sec. 78, Ch. 431, L. 1975; R.C.M. 1947, 7-126.

32-2-303. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 25, Ch. 57, L. 1927; re-en. Sec. 6355.26, R.C.M. 1935; amd. Sec. 79, Ch. 431, L. 1975; R.C.M. 1947, 7-127.

32-2-304. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 26, Ch. 57, L. 1927; re-en. Sec. 6355.27, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-128.

32-2-305. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 1, Ch. 154, L. 1931; re-en. Sec. 6355.8, R.C.M. 1935; amd. Sec. 71, Ch. 431, L. 1975; R.C.M. 1947, 7-108.

32-2-306. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 36, Ch. 57, L. 1927; re-en. Sec. 6355.37, R.C.M. 1935; amd. Sec. 82, Ch. 431, L. 1975; R.C.M. 1947, 7-138.

32-2-307. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 45, Ch. 57, L. 1927; amd. Sec. 2, Ch. 11, L. 1933; re-en. Sec. 6355.46, R.C.M. 1935; amd. Sec. 84, Ch. 431, L. 1975; R.C.M. 1947, 7-147(part); amd. Sec. 1038, Ch. 56, L. 2009.

32-2-308. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 45, Ch. 57, L. 1927; amd. Sec. 2, Ch. 11, L. 1933; re-en. Sec. 6355.46, R.C.M. 1935; amd. Sec. 84, Ch. 431, L. 1975; R.C.M. 1947, 7-147(part).

32-2-309. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 48, Ch. 57, L. 1927; re-en. Sec. 6355.49, R.C.M. 1935; amd. Sec. 86, Ch. 431, L. 1975; R.C.M. 1947, 7-150; amd. Sec. 14, Ch. 5, L. 1983.

Part 4
Operation and Regulation
(Repealed)

32-2-401. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 12, Ch. 57, L. 1927; amd. Sec. 1, Ch. 163, L. 1929; amd. Sec. 1, Ch. 11, L. 1933; re-en. Sec. 6355.13, R.C.M. 1935; amd. Sec. 1, Ch. 80, L. 1939; amd. Sec. 1, Ch. 164, L. 1943; amd. Sec. 1, Ch. 337, L. 1975; amd. Sec. 72, Ch. 431, L. 1975; R.C.M. 1947, 7-113(part); amd. Sec. 15, Ch. 5, L. 1983; amd. Sec. 1, Ch. 243, L. 1989; amd. Sec. 1039, Ch. 56, L. 2009.

32-2-402. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 12, Ch. 57, L. 1927; amd. Sec. 1, Ch. 163, L. 1929; amd. Sec. 1, Ch. 11, L. 1933; re-en. Sec. 6355.13, R.C.M. 1935; amd. Sec. 1, Ch. 80, L. 1939; amd. Sec. 1, Ch. 164, L. 1943; amd. Sec. 1, Ch. 337, L. 1975; amd. Sec. 72, Ch. 431, L. 1975; R.C.M. 1947, 7-113(part); amd. Sec. 5, Ch. 275, L. 1981; amd. Sec. 1, Ch. 9, L. 1983.

32-2-403. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 12, Ch. 57, L. 1927; amd. Sec. 1, Ch. 163, L. 1929; amd. Sec. 1, Ch. 11, L. 1933; re-en. Sec. 6355.13, R.C.M. 1935; amd. Sec. 1, Ch. 80, L. 1939; amd. Sec. 1, Ch. 164, L. 1943; amd. Sec. 1, Ch. 337, L. 1975; amd. Sec. 72, Ch. 431, L. 1975; R.C.M. 1947, 7-113(part); amd. Sec. 1040, Ch. 56, L. 2009.

32-2-404. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 12, Ch. 57, L. 1927; amd. Sec. 1, Ch. 163, L. 1929; amd. Sec. 1, Ch. 11, L. 1933; re-en. Sec. 6355.13, R.C.M. 1935; amd. Sec. 1, Ch. 80, L. 1939; amd. Sec. 1, Ch. 164, L. 1943; amd. Sec. 1, Ch. 337, L. 1975; amd. Sec. 72, Ch. 431, L. 1975; R.C.M. 1947, 7-113(part); amd. Sec. 16, Ch. 5, L. 1983; amd. Sec. 1041, Ch. 56, L. 2009.

32-2-405. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 12, Ch. 57, L. 1927; amd. Sec. 1, Ch. 163, L. 1929; amd. Sec. 1, Ch. 11, L. 1933; re-en. Sec. 6355.13, R.C.M. 1935; amd. Sec. 1, Ch. 80, L. 1939; amd. Sec. 1, Ch. 164, L. 1943; amd. Sec. 1, Ch. 337, L. 1975; amd. Sec. 72, Ch. 431, L. 1975; R.C.M. 1947, 7-113(part).

32-2-406. Repealed. Sec. 136, Ch. 431, L. 2021.

History: (1), (2)En. Sec. 12, Ch. 57, L. 1927; amd. Sec. 1, Ch. 163, L. 1929; amd. Sec. 1, Ch. 11, L. 1933; re-en. Sec. 6355.13, R.C.M. 1935; amd. Sec. 1, Ch. 80, L. 1939; amd. Sec. 1, Ch. 164, L. 1943; amd. Sec. 1, Ch. 337, L. 1975; amd. Sec. 72, Ch. 431, L. 1975; Sec. 7-113, R.C.M. 1947; (3)En. Sec. 1, Ch. 5, Ex. L. 1933; re-en. Sec. 5309.35, R.C.M. 1935; amd. Sec. 1, Ch. 37, L. 1935; amd. Sec. 1, Ch. 24, L. 1937; Sec. 35-142, R.C.M. 1947; R.C.M. 1947, 7-113(part), 35-142(part); amd. Sec. 6, Ch. 36, L. 1979; amd. Sec. 1, Ch. 154, L. 1979; amd. Sec. 5, Ch. 137, L. 1989; amd. Sec. 2, Ch. 243, L. 1989; amd. Sec. 54, Ch. 10, L. 1993; amd. Sec. 20, Ch. 19, L. 2011.

32-2-407. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 1, Ch. 263, L. 1963; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-113.1; amd. Sec. 2, Ch. 154, L. 1979.

32-2-408. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 16, Ch. 57, L. 1927; amd. Sec. 1, Ch. 5, L. 1933; re-en. Sec. 6355.17, R.C.M. 1935; amd. Sec. 74, Ch. 431, L. 1975; R.C.M. 1947, 7-118; amd. Sec. 1042, Ch. 56, L. 2009.

32-2-409. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 17, Ch. 57, L. 1927; re-en. Sec. 6355.18, R.C.M. 1935; amd. Sec. 75, Ch. 431, L. 1975; R.C.M. 1947, 7-119; amd. Sec. 1043, Ch. 56, L. 2009.

32-2-410. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 18, Ch. 57, L. 1927; re-en. Sec. 6355.19, R.C.M. 1935; R.C.M. 1947, 7-120; amd. Sec. 17, Ch. 5, L. 1983.

32-2-411. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 19, Ch. 57, L. 1927; amd. Sec. 1, Ch. 167, L. 1931; re-en. Sec. 6355.20, R.C.M. 1935; R.C.M. 1947, 7-121.

32-2-412. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 21, Ch. 57, L. 1927; re-en. Sec. 6355.22, R.C.M. 1935; R.C.M. 1947, 7-123.

32-2-413. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 22, Ch. 57, L. 1927; re-en. Sec. 6355.23, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-124.

32-2-414. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 40, Ch. 57, L. 1927; re-en. Sec. 6355.41, R.C.M. 1935; R.C.M. 1947, 7-142.

32-2-415. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 41, Ch. 57, L. 1927; re-en. Sec. 6355.42, R.C.M. 1935; R.C.M. 1947, 7-143.

32-2-416. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 42, Ch. 57, L. 1927; re-en. Sec. 6355.43, R.C.M. 1935; R.C.M. 1947, 7-144; amd. Sec. 18, Ch. 5, L. 1983.

32-2-417. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 43, Ch. 57, L. 1927; re-en. Sec. 6355.44, R.C.M. 1935; R.C.M. 1947, 7-145; amd. Sec. 19, Ch. 5, L. 1983.

32-2-418. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 44, Ch. 57, L. 1927; re-en. Sed. 6355.45, R.C.M. 1935; R.C.M. 1947, 7-146; amd. Sec. 20, Ch. 5, L. 1983.

32-2-419. Repealed. Sec. 3, Ch. 243, L. 1989.

History: En. Sec. 46, Ch. 57, L. 1927; re-en. Sec. 6355.47, R.C.M. 1935; R.C.M. 1947, 7-148.

32-2-420. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Secs. 1, 2, Ch. 35, L. 1945; R.C.M. 1947, 7-158, 7-159.

32-2-421 through 32-2-430 reserved.

32-2-431. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 47, Ch. 57, L. 1927; re-en. Sec. 6355.48, R.C.M. 1935; amd. Sec. 85, Ch. 431, L. 1975; R.C.M. 1947, 7-149; amd. Sec. 21, Ch. 5, L. 1983.

32-2-432. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 1, Ch. 4, L. 1935; re-en. Sec. 6355.50, R.C.M. 1935; amd. Sec. 170, Ch. 431, L. 1975; R.C.M. 1947, 7-151; amd. Sec. 22, Ch. 5, L. 1983.

32-2-433 through 32-2-440 reserved.

32-2-441. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 1, Ch. 174, L. 1935; re-en. Sec. 6374.8, R.C.M. 1935; amd. Sec. 31, Ch. 71, L. 1977; R.C.M. 1947, 7-156; amd. Sec. 23, Ch. 5, L. 1983.

32-2-442. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 2, Ch. 174, L. 1935; re-en. Sec. 6374.9, R.C.M. 1935; R.C.M. 1947, 7-157.

Part 5
National Housing Act Loans
(Repealed)

32-2-501. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 1, Ch. 38, L. 1935; re-en. Sec. 6356.1, R.C.M. 1935; amd. Sec. 1, Ch. 80, L. 1943; R.C.M. 1947, 7-153; amd. Sec. 24, Ch. 5, L. 1983.

32-2-502. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 2, Ch. 38, L. 1935; re-en. Sec. 6356.2, R.C.M. 1935; R.C.M. 1947, 7-154; amd. Sec. 25, Ch. 5, L. 1983.

32-2-503. Repealed. Sec. 136, Ch. 431, L. 2021.

History: En. Sec. 3, Ch. 38, L. 1935; re-en. Sec. 6356.3, R.C.M. 1935; amd. Sec. 2, Ch. 80, L. 1943; R.C.M. 1947, 7-155; amd. Sec. 26, Ch. 5, L. 1983.

Part 6
General Provisions

32-2-601. Short title — application — purpose. (1) This chapter may be cited as the "Mutual Savings and Loan Association Act".

(2) A corporation that has been incorporated for the purpose of encouraging home ownership and thrift and making substantially all of its loans in qualified thrift investments is known in this chapter as a state mutual association of the department, which shall enforce all laws with respect to it.

(3) This chapter applies to:

(a) all mutual associations specified in 32-2-602;

(b) corporations that subject themselves to This chapter; and

(c) persons, partnerships, or corporations who by violating this chapter become subject to the penalties provided in this chapter.

(4) The purpose of this chapter is to provide the state with a sound system of state-chartered mutual associations by providing for and encouraging the development of state-chartered mutual associations while restricting their activities to the extent necessary to protect the interest of depositors. The purpose includes:

(a) the sound conduct of the business of mutual associations;

(b) the conservation of mutual association assets;

(c) the maintenance of adequate reserves against deposits;

(d) the opportunity for mutual associations to compete with other businesses, including but not limited to other financial organizations existing under the laws of this state, other states, the United States, and foreign countries;

(e) the opportunity for mutual associations to serve the citizens of this state;

(f) the opportunity for mutual associations to participate in and promote the economic progress of Montana and the United States; and

(g) the opportunity for the management of mutual associations to exercise business judgment in conducting the affairs of their institutions.

(5) A corporation operated for the purpose of encouraging home ownership and thrift and making substantially all of its loans in qualified thrift investments is known as a mutual association and is under the supervision of the department, which shall enforce all laws with respect to it.

(6) The mutual associations have continual succession and must be organized under the provisions of this chapter.

(7) This chapter does not restrict the activities of mutual associations for the purpose of protecting any person from competition from financial organizations and does not confer any right or cause of action on any competitor.

(8) This section constitutes the standard to be observed by the commissioner of banking and financial institutions in the exercise of authority under this chapter and provides guidelines in the construction and application of this chapter.

History: **En. Sec. 1, Ch. 431, L. 2021.**

32-2-602. General applicability. It is unlawful for any corporation, partnership, firm, or individual to engage in or transact business as a mutual association, as defined in 32-2-603, except by means of a corporation organized for that purpose.

History: **En. Sec. 2, Ch. 431, L. 2021.**

32-2-603. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Capital" means, with respect to a mutual association:

(a) retained earnings; or

(b) at the discretion of the commissioner, any other form of capital, subject to any applicable federal and state laws.

(2) "Commissioner" means the commissioner of banking and financial institutions as provided in 32-1-211.

(3) "Department" means the department of administration provided for in 2-15-1001.

(4) "Deposit" has the meaning provided in 12 C.F.R. 204.2, as amended. The term includes demand deposits, which includes all deposits, the payment of which may legally be required when demanded.

(5) "Division" means the division of banking and financial institutions of the department.

(6) "Federal savings association" means a federal savings and loan association or a federal savings bank doing business under authority granted by the office of the comptroller of the currency or the former office of thrift supervision.

(7) "Institution-affiliated party" means:

(a) any director, officer, or employee of or agent for a mutual association;

(b) any other person who has filed or is required to file a change-in-control notice pursuant to this chapter;

(c) any consultant, joint venture partner, or other person as determined by the commissioner who participates in the conduct of the affairs of an insured depository institution; and

(d) any independent contractor, including any attorney, appraiser, or accountant, who knowingly or recklessly participates in any violation of any law or rule, any breach of fiduciary duty, or any unsafe or unsound practice that caused or is likely to cause more than a minimal financial loss to or a significant adverse effect on the mutual association.

(8) "Insured depository institution" means a bank or savings association in which the deposits are insured by the federal deposit insurance corporation.

(9) "Member" means all holders of the mutual association's savings, demand, including other authorized members on accounts.

(10) "Mutual association" means any corporation that has been incorporated to conduct the business of receiving money on deposit from its members and making substantially all of its loans on one-to-four family real estate mortgage security. The term includes a savings and loan association formed without authority to issue stock.

(11) "Portfolio assets" has the same meaning as provided in 12 U.S.C. 1467a, as amended.

(12) "Qualified thrift investments" has the same meaning as provided in 12 U.S.C. 1467a, as amended.

(13) "Savings association" or "savings and loan association" means a savings association or savings bank organized under the laws of the United States or a building and loan association, savings and loan association, or similar entity organized under the laws of a state. "Savings association" also includes a state mutual association that elects to operate as a savings and loan association under this chapter.

(14) (a) "Service provider" means an entity that provides one or more of the following services to a mutual association:

(i) data processing services;

(ii) activities supporting financial services, including but not limited to lending, funds transfer, fiduciary activities, trading activities, and deposit taking;

(iii) internet-related services, including but not limited to web services and electronic bill payments, mobile applications, system and software development and maintenance, and security monitoring; and

(iv) activities related to the business of mutual associations.

(b) The term does not include:

(i) an entity that provides telecommunications service, internet access service, internet transport services, voice-over internet protocol service, or other internet protocol-enabled service; or

(ii) a general audience or communications platform.

History: En. Sec. 3, Ch. 431, L. 2021.

32-2-604 through 32-2-606 reserved.

32-2-607. Notice of violation — administrative hearing — penalties — liability. (1) If the department has reasonable cause to believe that a person has violated this chapter, a rule promulgated under this chapter, or an order issued by the department or has made a material misrepresentation to the department by act or omission, the department may issue an administrative notice stating the alleged violation to the person.

(2) The Montana Administrative Procedure Act's provisions for contested cases and judicial review of contested cases apply to civil violations of this chapter.

(3) Any mutual association that maintains procedures reasonably adapted to avoid any inadvertent and unintentional error and, as a result of such an error, fails to submit or publish any report or information required by this chapter within the period of time specified by this chapter, or submits or publishes any false or misleading report or information, or inadvertently transmits or publishes any report that is minimally late is subject to a penalty of not more than $500 for each day during which the failure continues or the false or misleading information is not corrected. The mutual association has the burden of proving by a preponderance of the evidence that an error was inadvertent and unintentional and that a report was inadvertently transmitted or published late.

(4) Any mutual association that fails to submit or publish any report or information required within the period of time specified by this chapter or submits or publishes any false or misleading report or information in a manner not described in subsection (3) is subject to a penalty of not more than $5,000 for each day during which the failure continues or the false or misleading information is not corrected.

(5) If any mutual association knowingly or with reckless disregard for the accuracy of any information or report described in subsection (4) submits or publishes any false or misleading report or information, the division may assess a penalty of not more than $10,000 for each day during which the failure continues or the false or misleading information is not corrected.

(6) The department's remedies specified in this chapter are cumulative.

(7) All civil penalties collected pursuant to this section must be deposited in the special revenue account for use by the department in its supervision of mutual associations.

History: En. Sec. 4, Ch. 431, L. 2021.

32-2-608. Criminal liabilities. (1) A person who knowingly and purposefully violates any provision of this chapter or any rule or order under this chapter shall upon conviction be fined not more than $5,000 or imprisoned not more than 10 years, or both. However, if the person has been previously convicted of a felony in any way involving financial institutions, the person shall be imprisoned for not less than 1 year.

(2) The commissioner may refer evidence that may be available concerning violations of this chapter or of any rule or order under this chapter to the attorney general or the proper prosecuting attorney, who may in the prosecutor's discretion, with or without a reference, institute the appropriate criminal proceedings under this chapter.

(3) The provisions of this chapter do not limit the power of the state to punish any person for any conduct that constitutes a crime.

History: En. Sec. 5, Ch. 431, L. 2021.

Part 7
Department Responsibility

32-2-701. Examination and supervision by department — duties — rulemaking. (1) The department shall:

(a) exercise constant supervision over the books and affairs of all mutual associations doing business in this state; and

(b) investigate the methods of operation and conduct of business of the mutual associations and their systems of accounting to ascertain whether the methods and systems are in accordance with law and sound principles of mutual associations.

(2) Except as provided in subsection (3), the department shall:

(a) examine, at least once every 24 months, each mutual association and verify the assets and liabilities of each and investigate the character and value of the assets of each to ascertain with reasonable certainty that the values are correctly carried on the books; and

(b) submit in writing to the examined mutual association a report of the examination's findings no later than 60 days after the completion of the examination.

(3) The department may accept as the examination required by subsection (2) the findings or results of an examination of a mutual association that was made by a federal or state regulatory agency or insuring agency of the United States authorized to make the examination.

(4) Whenever a mutual association is subject to examination by the department that causes any of the services listed for a service provider in 32-2-603 to be performed by itself, by contract or otherwise, the performance is subject to regulation and examination by the department to the same extent as if the services were performed by the mutual association itself.

(5) The department may:

(a) enter into joint examination or joint enforcement actions with other regulatory agencies having concurrent jurisdiction over a mutual association or service provider;

(b) enter into agreements with any depository institution regulatory agency that has concurrent jurisdiction over a mutual association or service provider to:

(i) engage the services of the agency's examiners at a reasonable rate of compensation; or

(ii) provide the services of the department's examiners to the agency at a reasonable rate of compensation; and

(c) disclose to a mutual association information about a service provider of the mutual association.

(6) The department may in the performance of its official enforcement duties:

(a) examine under oath any of the officers, directors, agents, clerks, customers, or depositors of a mutual association regarding the affairs and business of the mutual association; and

(b) issue subpoenas and administer oaths.

(7) In the case of a refusal to obey a subpoena issued by the department, the refusal may be reported to the district court of the district in which the mutual association is located. The court shall enforce obedience to the subpoena in the manner provided by law for enforcing obedience to the process of the court.

(8) In all matters relating to its official duties, the department has the same power possessed by courts of law to issue subpoenas and have them served and enforced.

(9) All officers, directors, agents, and employees of mutual associations doing business under this chapter and all persons having dealings with or knowledge of the affairs or methods of a mutual association shall:

(a) at all times afford reasonable facilities for examinations;

(b) provide responses and reports to the department as required by the department;

(c) attend hearings and answer under oath the department's inquiries;

(d) produce and exhibit any books, accounts, documents, and property the department desires to inspect; and

(e) in all things aid the department in the performance of its duties.

(10) The provisions of 32-1-212 apply to this chapter.

(11) The department may adopt rules to implement this section.

History: En. Sec. 6, Ch. 431, L. 2021.

32-2-702. Payments by mutual associations. Each mutual association under the supervision of the department shall pay to the department fees set by the department by rule to recover all of the costs of administering the program for supervision of mutual associations. The department may amend the rule setting the fees on or before June 1 and December 1 of each year. The funds collected must be deposited in the state special revenue fund for the use of the department in its supervision of mutual associations.

History: En. Sec. 7, Ch. 431, L. 2021.

32-2-703. Examination — request of directors. If requested in writing, upon the authority of a majority of the board of directors of any mutual association to make an examination of the mutual association, the department shall do so.

History: En. Sec. 8, Ch. 431, L. 2021.

32-2-704. Department rulemaking. (1) The department may promulgate reasonable rules and orders concerning bookkeeping and accounting by state mutual associations, including the keeping of reasonable credit information, information in connection with assets, or information in connection with charged-off items.

(2) The department may adopt uniform rules to govern the examination and reports of mutual associations and prescribe the form in which mutual associations report their assets, liabilities, and reserves.

(3) The department may promulgate reasonable rules concerning applications for and determinations on applications for the formation, relocation, closure, and sale of branch mutual associations.

(4) The department may adopt rules, issue orders and declaratory statements, disseminate information, and exercise its discretion to effectuate the purposes, policies, and provisions of this chapter.

History: En. Sec. 9, Ch. 431, L. 2021.

32-2-705. Reliance on order — limit on liability. (1) A person acting in good faith reliance on a rule, order, or declaratory statement issued by the division is not subject to any criminal, civil, or administrative liability for the action if a subsequent decision by a court of competent jurisdiction invalidates the rule, order, or declaratory statement.

(2) In the case of an order or declaratory statement that is not of general application, only the person to whom the order or declaratory statement was issued is entitled to rely on it unless a third person is dealing with material facts or circumstances that are substantially the same as those on which the order or declaratory statement was based.

History: En. Sec. 10, Ch. 431, L. 2021.

32-2-706. Reports to department. (1) A mutual association shall make to the department regular call reports at least four times each year according to the form that may be prescribed by the department, verified by oath or affirmation of the president, vice president, or cashier of the mutual association, and attested by the signature of at least two of the directors other than the subscribing officer.

(2) Each call report must exhibit in detail and under appropriate schedules the resources and liabilities of the mutual association at the close of business on any past day specified by the department. The past day specified by the department, under the provisions of this section, must be the day designated by the comptroller of the currency of the United States for reports of national banking associations.

(3) The call report must be transmitted to the department within 30 days after the past day specified under subsection (2). A mutual association's successful and timely electronic transmittal of its call report to the applicable federal regulatory authority satisfies the mutual association's obligation to transmit the report to the department. The original signature page of the mutual association's call report that complies with subsection (1) must be permanently retained by the mutual association and available for the department's review.

History: En. Sec. 11, Ch. 431, L. 2021.

32-2-707. Special reports to department. In addition to the information obtained from the call report required by 32-2-706, the department may also require a mutual association to furnish a special report in writing, verified as required by 32-2-706, if in its judgment the special report is necessary to inform it fully of the actual financial condition and affairs of the mutual association.

History: En. Sec. 12, Ch. 431, L. 2021.

32-2-708 and 32-2-709 reserved.

32-2-710. Confidentiality — penalties. (1) (a) Reports and statement under 32-2-701, 32-2-703, and 32-2-707 are confidential. Except for information made public by the federal deposit insurance corporation or another federal mutual association authority's publicly accessible website, any information contained in the reports and statements is confidential. Except as provided in subsection (1)(b), confidential information may not be disclosed to persons who are not officially associated with the department and must be used by the department only to further its official duties.

(b) The department may exchange information with federal financial institution regulatory agencies and with the financial regulatory departments of other states. The department may furnish reports of its examination findings under 32-2-701 and 32-2-703 to a federal home loan bank, as defined in the Federal Home Loan Bank Act of 1932, 12 U.S.C. 1422. The department may furnish information to the legislative auditor for use in pursuit of official duties. A prosecuting official may obtain the information by court order.

(2) Any knowledge or information gained or discovered by the department in pursuance of its powers or duties is confidential information of the department. The information may not, except as provided in subsection (1)(b), be disclosed to any person not officially associated with the department. The information must be used by the department only to further its official duties.

(3) An employee or agent of the department who violates this section or willfully makes a false official report as to the condition of a mutual association must be removed from office and is guilty of a felony. Upon conviction, the person shall be fined an amount not exceeding $1,000, be imprisoned in a state correctional facility for a term not exceeding 5 years, or both.

History: En. Sec. 13, Ch. 431, L. 2021.

32-2-711. Prohibited practices. (1) It is unlawful for any person to knowingly and purposefully:

(a) make any material false statement of facts, statement of accounts, or report to the department; or

(b) make any false entries in the books of the mutual association.

(2) It is unlawful for any person to knowingly exhibit false documents with the intent to deceive any person authorized to examine a mutual association.

(3) Violations of this section are punishable as provided in 32-2-608.

History: En. Sec. 14, Ch. 431, L. 2021.

Part 8
Formation and Reorganization

32-2-801. Formation. (1) Five or more individuals who are residents of this state may, with the approval of the commissioner, incorporate a mutual association.

(2) The persons proposing to incorporate a mutual association shall apply for approval to incorporate by submitting the application in a form prescribed by the commissioner, which must be under oath and include all of the following plus any additional information that the department may require by rule as necessary or appropriate in the particular instance for the protection of depositors, borrowers, or members and the public interest:

(a) the proposed articles of incorporation and bylaws set forth in 32-2-805 through 32-2-807;

(b) an application for reservation of a name in accordance with 35-14-402, if reservation is desired by the incorporators and has not been previously filed; and

(c) information to demonstrate the proposed mutual association will satisfy the following requirements:

(i) a persuasive showing that there is a reasonable public necessity and demand for a new mutual association at the proposed location;

(ii) that the mutual association will be managed by persons of good moral character and financial integrity who have sufficient management experience to ensure that the mutual association will be operated safely and soundly;

(iii) a persuasive showing that the new mutual association will have sufficient volume of business to ensure solvency and that establishment of the new mutual association organized under the laws of this state will be in the public interest;

(iv) the proposed minimum amount of initial capital contribution to be deposited, which must be set by the commissioner;

(v) an application fee, which must be set by the department by rule; and

(vi) Any other information the commissioner requires by rule or in a specific application.

History: En. Sec. 16, Ch. 431, L. 2021.

32-2-802. Notice of acceptance of application. If the department determines that a completed application has been received, it shall issue a notice of acceptance of application to the applicant.

History: En. Sec. 17, Ch. 431, L. 2021.

32-2-803. Notice of proposed incorporation. (1) (a) Within 10 days after receipt from the department of a notice of acceptance of an application, the applicant shall publish notice of the proposed incorporation in a newspaper of general circulation in the county where the mutual association's initial main office is to be located. The applicant shall publish the notice once a week for 2 weeks and furnish a certified copy of the affidavit of publication to the department.

(b) The notice shall specify the name of the proposed mutual association, its location, the amount of the proposed capital, the names of the incorporators, the address of the commissioner, and the date by which comments on the application must be filed with the commissioner, which is 30 days after the date of the first publication of the notice.

(2) If any comments on the application are filed with the commissioner within the 30-day period prescribed in subsection (1), the commissioner shall determine whether the comments are relevant to the requirements for incorporation of the mutual association and, if so, investigate the comments in the manner the commissioner considers appropriate.

History: En. Sec. 18, Ch. 431, L. 2021.

32-2-804. Department investigation. (1) The department may gather all available information relative to an application. The department may also make, or cause to be made, any investigations of any individual associated with the applicant as may be warranted under the circumstances, including a full background check and credit check.

(2) The department may use any administrative procedure necessary, including the taking of depositions, discovery, subpoenas, and the production of documents, to investigate an application. The Montana Administrative Procedure Act applies.

History: En. Sec. 19, Ch. 431, L. 2021.

32-2-805. Articles of incorporation. (1) A mutual association's articles of incorporation must contain the following:

(a) the information required by 35-14-202(1);

(b) the name of the city or town and county within the state in which the principal office of the corporation is to be located;

(c) the names and business addresses of the initial incorporators;

(d) the number of the board of directors and the names of those agreed on for the first year; and

(e) the purpose for which the mutual association is formed, which may be set forth by the use of the general terms defined in this chapter, with reference to each line of business in which the proposed corporation desires to engage.

(2) A mutual association may not adopt or use the name of any other mutual association, and the corporation name must comply with 35-14-401(2) through (4) and 32-1-402.

(3) A mutual association may not be organized or incorporated until the articles of incorporation have been reviewed and approved by the department and until the mutual association has obtained a certificate from the department authorizing the proposed corporation to transact the business specified in the articles of incorporation within this state.

(4) A mutual association may not amend or restate its articles of incorporation until its articles of amendment or restatement have been reviewed and approved by the department. A mutual association shall make a true copy of its articles of incorporation and bylaws and all related amendments available to account holders at all times in each office of the mutual association and shall on request and payment of a reasonable copying fee deliver to any account holders a copy of the articles of incorporation and bylaws and related amendments.

History: **En. Sec. 20, Ch. 431, L. 2021.**

32-2-806. Incorporation. The proposed articles of incorporation must be presented to the department, together with an application in writing in the form prescribed by the department, for a certificate authorizing the proposed corporation to transact the business specified in the articles of incorporation within this state.

History: **En. Sec. 21, Ch. 431, L. 2021.**

32-2-807. Bylaws. (1) The bylaws must be in conformity with the provisions of this chapter and must be open to inspection by the members at the principal place of business during regular business hours.

(2) The bylaws, among other things, must provide for:

(a) the character and method of conducting the business of the mutual association, with rules governing the addition of members and the amount of the membership fee;

(b) the annual meeting of the members;

(c) the annual election and qualification of directors and the term or period during which the directors shall serve;

(d) the appointment of officers;

(e) the adoption, ratification, and amendment of the bylaws, which may be made either by the members or by the board of directors;

(f) the method of voting at the annual meeting; and

(g) the periodic investigation of the business and condition of the mutual association.

(3) The bylaws and any change or amendment of the bylaws are not effective until first reviewed and approved by the department, and a mutual association may not commence the transaction of business until after the bylaws have been reviewed and approved by the department.

History: **En. Sec. 22, Ch. 431, L. 2021.**

32-2-808. Capital. (1) The capital of a mutual association must be an amount determined by the commissioner based on the amount and character of the anticipated business of the mutual association and the safety of prospective depositors.

(2) As used in this section, "capital" means the initial funding required to organize a mutual association.

History: **En. Sec. 23, Ch. 431, L. 2021.**

32-2-809. Review of application. (1) The commissioner shall examine all of the facts connected with the application to determine if all of the requirements of law are met, including but not limited to the following:

(a) the proposed articles of incorporation and bylaws, application for reservation of name, applicable fees, and other items required meet the requirements of this chapter;

(b) the population and economic characteristics of the area to be served afford reasonable promise of adequate support for the proposed mutual association;

(c) the competence, experience, character and fitness, financial resources, and integrity of the proposed directors and officers are to command the confidence of the community and warrant the belief that the business of the proposed mutual association will be honestly and efficiently conducted;

(d) the capital of the proposed mutual association is adequate in relation to the amount and character of the anticipated business of the association and the safety of prospective depositors;

(e) the commissioner is satisfied, based on the investigation conducted pursuant to 32-2-804 and any other facts within the knowledge of the commissioner, that the mutual association is otherwise entitled to commence business; and

(f) the commissioner has received from the federal deposit insurance corporation written confirmation that it has approved the mutual association's application to become an insured state savings association as defined in section 3(h) of the Federal Deposit Insurance Act, 12 U.S.C. 1813(h), as amended, or the mutual association has received satisfactory assurance from the federal deposit insurance corporation that the proposed mutual association will be accepted for insurance if the incorporators comply with certain slated minor requirements imposed by the federal deposit insurance corporation. The minor requirements must be of a type and character that the commissioner determines can be promptly complied with by the incorporators without serious difficulties.

(2) Within 180 days following the date of acceptance of the application, the commissioner shall approve or disapprove the application of the proposed mutual association on the basis of the examination. In giving approval, the commissioner may impose conditions to be met prior to the issuance of a certificate of authority to commence business under this chapter.

(3) If the commissioner approves the application, the commissioner shall notify the applicant of the approval and proceed with the steps to complete the application.

(4) If the commissioner denies the application, the denial must be in writing in the form of findings of fact and conclusions of law and order. The applicant may file an administrative appeal pursuant to the Montana Administrative Procedure Act.

(5) The findings and order may not be disclosed to any other party and may not be subject to public disclosure under 32-2-710 unless the findings of fact and the conclusions of law and order are appealed pursuant to the Montana Administrative Procedure Act.

History: **En. Sec. 24, Ch. 431, L. 2021.**

32-2-810. Certificate of authority to commence business. (1) A mutual association organized under this chapter may not accept deposits, incur indebtedness, or transact any business other than business that is incidental to its organization until it receives a certificate of authority to commence business issued by the commissioner.

(2) A mutual association organized under this chapter may not commence business until the capital required in its permission to organize has been deposited to the credit of the financial institution in a depository designated by the directors. When the required capital is deposited, a complete list of the capital depositors, with the name, address, occupation, and amount of capital deposited by each, must be filed with the commissioner, and the list must be verified by the president and secretary of the mutual association.

(3) When the mutual association has completed all steps necessary to begin business, the association shall file a report with the commissioner certifying that it has done everything required by the commissioner before it can be authorized to commence business.

(4) Upon receipt of the report referred to in subsection (3), the commissioner shall examine the affairs of the mutual association and determine whether the mutual association has complied with all of the requirements necessary to entitle it to engage in business.

(5) All transactions conducted by a person in violation of this section are void.

History: **En. Sec. 25, Ch. 431, L. 2021.**

32-2-811. Failure to commence business. (1) Any mutual association that fails to commence business as a financial institution within 1 year after receiving a certificate of authorization forfeits that certificate and shall cease all activities. The commissioner shall certify to the secretary of state that the certificate of authority has been forfeited so that the mutual association's articles of incorporation may be terminated by the secretary of state.

(2) On forfeiture, the contributors of initial capital deposits of the mutual association are entitled to the return of any amounts they have paid to the institution, and all expenses incurred in the organization must be borne by the original organizers who were named in the application for permission to organize.

History: **En. Sec. 26, Ch. 431, L. 2021.**

32-2-812 through 32-2-815 reserved.

32-2-816. Conversion from federal mutual savings and loan association — state mutual savings and loan association. (1) Any federal mutual savings and loan association organized and existing under the laws and regulations of the United States and duly authorized to operate and actually operating in Montana may convert into a Montana mutual savings and loan association operating under the provisions of this chapter, with the same force and effect as though originally incorporated under the provisions of this chapter, by complying with the rules and regulations of the federal regulatory authority and also by following the procedure set forth in subsection (2).

(2) (a) The federal mutual association shall submit a plan of conversion to the commissioner. When the plan, either with or without amendment, has been approved by the commissioner, it must be submitted to the members of the mutual association as provided in subsection (2)(b).

(b) A meeting of the members must be held on not less than 30 days' notice to each member. Notice of the meeting must be mailed to each member, postage prepaid, to the last-known address of the member shown on the books of the mutual association.

(c) At the meeting of the members of the mutual association, the members may by affirmative vote of a majority of members present, in person or by proxy, resolve to convert the federal mutual association to a state mutual association. A copy of the minutes of the meeting of the members, certified by an appropriate officer of the mutual association, must be filed with the commissioner, accompanied by a conversion fee, which must be set by the department by rule.

(d) Within 30 days after the approval of the proceedings by the commissioner, the mutual association shall file with the commissioner a copy of the proposed articles of incorporation and proposed bylaws of the mutual association. The proposed articles of incorporation and bylaws must conform to the provisions of the laws of this state.

(e) Upon receipt of the proposed articles of incorporation and bylaws, the commissioner shall make a careful examination and investigation of the facts connected with the conversion of the mutual association, including an examination of its affairs generally and a determination of its assets and liabilities. If it appears that the mutual association, if converted, would lawfully be entitled to conduct business as a state mutual association pursuant to the provisions of this chapter, the commissioner shall issue a final approval to the mutual association.

(f) The mutual association shall finalize the articles of incorporation and bylaws and, upon payment of the filing fees by the mutual association, the division shall file the certificate of authority and articles of incorporation with the secretary of state. Upon issuance and recordation of the certificate of authority and articles of incorporation, the mutual association shall file them with the appropriate federal regulatory authority. Upon the filing, the mutual association ceases to be a federal association and is converted to a state mutual association.

(g) (i) Upon conversion, all of the property of the federal mutual association, including all of its rights, title, and interest in and to all property of any kind whether real, personal, or mixed, and things in action, and every right, privilege, interest, and asset of any conceivable value or benefit then existing, belonging, or pertaining to it, or that would insure to it, must immediately by act of law and without any conveyance or transfer and without any further act or deed be vested in and become the property of the state mutual association, which shall have, hold, and enjoy the same in its own right as fully and to the same extent as if the same was possessed, held, or enjoyed by the federal savings association.

(ii) The state mutual association is deemed to be a continuation of the entity and the identity of the federal mutual association, operating under and pursuant to the provisions of this chapter, and all rights, obligations, and relations of the federal savings association to or in respect to any person, estate, or creditor, depositor, trustee, or beneficiary of any trust, and to or in respect to any executorship or trusteeship or other trust or fiduciary function, must remain unimpaired. The state mutual association shall by operation of this section succeed to all the rights, obligations, relations, and trusts, and the associated duties and liabilities, and shall execute and perform each and every right, obligation, trust, and relation in the same manner as if the state mutual association had itself assumed the trust or relation, including the related obligations and liabilities.

History: En. Sec. 27, Ch. 431, L. 2021.

32-2-817. Conversion into federal savings and loan association. (1) Any mutual association eligible to become a federal savings and loan association may convert itself into a federal savings and loan association by following the procedure in subsection (2).

(2) (a) At any regular meeting or special meeting of the members of the mutual association called to consider the action and held in accordance with the laws governing the mutual association, the members, by an affirmative vote of the majority, in person or by proxy, may declare by resolution the determination to convert the state mutual association into a federal savings and loan association.

(b) A copy of the minutes of the meeting of the members verified by the affidavit of the president or vice president and the secretary of the meeting must be filed with the department within 10 days after the meeting. The verified copy of the minutes of the meeting when filed is presumptive evidence of the holding of and action of the meeting.

(c) Within a reasonable time and without any unnecessary delay after the adjournment of the meeting of the members, the mutual association shall take any action necessary to make it a federal savings and loan association. Within 10 days after receipt of the federal charter, the charter must be filed with the department. Upon filing, the mutual association ceases to be a state mutual association and is thereafter a federal savings and loan association.

History: En. Sec. 28, Ch. 431, L. 2021.

32-2-818. Requirements of state mutual association. A mutual association must have its qualified thrift investments:

(1) equal or exceed 50% of its portfolio assets; and

(2) continue to equal or exceed 50% of its assets on a monthly average basis in 9 out of every 12 months.

History: En. Sec. 29, Ch. 431, L. 2021.

32-2-819. Directors — meetings — officers. (1) Within 30 days after the corporate existence of a mutual association begins, the directors of the mutual association shall hold an organizational meeting and shall elect officers pursuant to the provisions of this chapter and the bylaws of the mutual association. At the organizational meeting, the directors shall take other action that is appropriate for beginning the transaction of business by the mutual association. The department may extend, by order, the time within which the organizational meeting must be held.

(2) The incorporators of the mutual association shall serve as directors until the first meeting of the members to be held at the time provided for by this chapter or until their successors are elected and qualified, after which the directors will be elected by the members of the mutual association in accordance with the provisions of this chapter and the bylaws of the mutual association.

(3) The directors, unless otherwise provided by the bylaws of the mutual association, shall elect or appoint all officers of the mutual association. The directors, when appointed or elected, shall file with the department their oath of office, as provided in election or appointment of mutual association directors. Meetings of the board of directors must be held at least once each month.

History: En. Sec. 30, Ch. 431, L. 2021.

32-2-820. Board of directors — qualifications, tenure, and vacancies. (1) The affairs of the mutual association must be managed by a board of directors consisting of no fewer than three persons. At least two-thirds of the board must be residents of this state. Directors need not be members of the corporation unless required by the articles of incorporation or bylaws. A person who has been convicted of a felony may not be elected a director.

(2) (a) The directors must be elected for a term of 1 year at the annual meeting of the members. The annual meeting must be held before April 15 of each calendar year. If the election is not held on the day fixed for the annual meeting, the corporation is not dissolved, but an election may be held at any other time agreeable to the bylaws of the corporation, and the persons elected will hold their office until successors are elected and qualified.

(b) Every director shall take and subscribe an oath that the director will diligently and honestly perform the director's duty in the office and that the director will not knowingly violate or permit a violation of any of the provisions of this chapter. The oaths must be made in duplicate. One copy must be transmitted to and filed with the department, and one copy must be kept on file in the office of the mutual association.

History: En. Sec. 31, Ch. 431, L. 2021.

32-2-821. Selection of officers and employees — minutes of meetings. (1) The board of directors of a mutual association shall hold a meeting at least quarterly.

(2) The board of directors may elect a president, one or more vice presidents, a cashier, one or more assistant cashiers, and other officers and employees that the board may from time to time consider to be in the best interest of the mutual association, and the board shall fix their compensation. The president must be chosen from the board of directors.

(3) (a) The board of directors shall keep a correct report of the meetings of the board and of the members. This record of the meetings of the board of directors must be signed, manually or electronically, by the presiding officer and the person responsible for preparing the minutes.

(b) The minutes must be read and approved at the following meeting of the board of directors, and the minutes of the following meeting must show that fact.

(c) A person who makes a material false entry in the record of the board meetings or who makes a material change or alteration of an entry made in the record is subject to removal pursuant to 32-2-936.

History: En. Sec. 32, Ch. 431, L. 2021.

32-2-822. Members — proxies. (1) A depositor of a mutual association is a voting member and has an ownership interest in the mutual association as may be provided in the terms and conditions set forth in the articles of incorporation and bylaws of the mutual association.

(2) The bylaws of a mutual association may provide that all borrowers from the mutual association are members and, if so, must provide for their rights and privileges.

(3) Unless otherwise provided in the articles of incorporation or bylaws, a proxy granted by a depositor to the officers and directors of a mutual association expires on the date specified in the proxy. If no date is specified, the authority granted by the proxy is perpetual.

(4) The written proxy appointment is separate and distinct from any deposit agreement, any loan agreement, or any other agreement, statement, document, or disclosure provided by a mutual association to a depositor.

(5) At least once every year, the board of directors of a mutual association shall, by resolution, cause the secretary of the mutual association to mail to every member of the mutual association a blank form of proxy, and the member may withdraw a former proxy and substitute a new proxy for the former proxy. A proxy continues in force and is binding on the member until the proxy is revoked or another proxy is substituted.

History: En. Sec. 33, Ch. 431, L. 2021.

32-2-823. Right of examination by member. A member of a mutual association incorporated under the laws of this state who is not a director may not inspect the books and records of the mutual association showing its transactions with a customer. A member may inspect the books and records of the mutual association as provided in 35-14-1602.

History: En. Sec. 34, Ch. 431, L. 2021.

32-2-824. Federal savings association powers extended to state mutual associations. (1) A mutual association organized under the laws of this state may engage in any activity or business in which the mutual association could engage if it were operating as a federal savings association if the power or activity is not expressly prohibited or limited by the laws of this state and:

(a) if the power or activity is clearly authorized to federal savings associations by federal statute, regulations, or interpretive ruling issued or adopted by a federal banking regulator having jurisdiction over federal savings associations; and

(b) upon application to and approval by the department.

(2) The department may adopt rules to govern the application procedure under this section. The department shall act on an application under this section within 15 days after receipt of the application. The department may, for good cause, extend the time period for processing an application under this section for an additional 15 days. If the department fails to act on the

application within 15 days after receipt of the application and does not extend the time period for good cause, the state mutual association may engage in the activity requested without the approval of the department.

History: En. Sec. 35, Ch. 431, L. 2021.

32-2-825. Surrender of charter by state mutual association. (1) Any mutual association that will become a corporation for carrying on the business of a mutual association under the laws of the United States ceases to be a corporation under the laws of this state.

(2) The members of the board of directors last in office when the corporation became a corporation under the laws of the United States continues to be the board of directors of the corporation, with power to take all necessary measures to carry out and perfect the organization by signing the articles of association and the organization certificate and adopting the regulations as may be just and proper and not inconsistent with the acts of congress.

(3) A change from a state mutual association to a federal savings association may not release the mutual association from its obligations to pay and discharge all of the liabilities created by law or incurred by the mutual association before becoming a federal savings association or any tax imposed by the laws of this state up to the date of the mutual association becoming a federal savings association, in proportion to the time that has elapsed since the next preceding payment.

History: En. Sec. 36, Ch. 431, L. 2021.

32-2-826. Membership in federal home loan bank. (1) A mutual association may be a member of the federal home loan bank of this federal reserve banking district as far as may be compatible with the constitution of this state and the laws of the United States.

(2) The department, on request of any federal home loan bank, shall furnish that bank any information it may have relative to the finances, manner of business, methods of bookkeeping, and any other information relating to a mutual association that is a member of, seeking to become a member of, a borrower from, or seeking to become a borrower from a federal home loan bank.

History: En. Sec. 37, Ch. 431, L. 2021.

32-2-827. Merger of mutual associations. (1) (a) Any mutual association doing business in this state that has been in business for at least 5 years may, with the approval of the department if any merger party is a mutual association organized under the laws of this state, merge into one mutual association on terms and conditions lawfully agreed on by a majority of the board of directors of each mutual association proposing to merge. After the directors agree to a plan of merger and the department approves the plan of merger, the majority of the members of the merging mutual association must approve the proposed merger.

(b) Except as otherwise expressly provided in this chapter, a merger under this subsection (1) is governed by Title 35, chapter 14, if the resulting mutual association is organized under the laws of this state.

(2) Upon merger:

(a) each mutual association merging party merges into the resulting mutual association and the separate existence of every merging party except the resulting mutual association ceases;

(b) title to all real, personal, and mixed property owned by each merging party is vested in the resulting mutual association without reversion or impairment and without the necessity of any instrument of transfer;

(c) the resulting mutual association has all of the liabilities, duties, and obligations of each merger party, including obligations as fiduciary, personal representative, administrator, trustee, or guardian; and

(d) the resulting mutual association has all of the rights, powers, and privileges of each merger party, including appointment to the office of personal representative, administrator, trustee, or guardian under any will or other instrument made prior to the merger and in which a merger party was nominated to the office by the maker of the will or other investment.

(3) Upon merger, the resulting mutual association shall designate and operate one of the prior main offices of the merging mutual associations as its main mutual association office and

the resulting mutual association may maintain and continue to operate the main office of each of the other merging mutual associations as a branch.

(4) (a) Upon merger, the resulting mutual association may:

(i) maintain the branches and other offices previously maintained by the merging mutual associations; and

(ii) establish, acquire, or operate additional branches of mutual associations at any location where any mutual association involved in the merger could have established, acquired, or operated a branch under applicable federal or state law if that mutual association had not been a party to the merger.

(b) A resulting mutual association organized under the laws of this state that intends to establish, acquire, or operate a branch under subsection (4)(a)(ii) must receive prior approval from the department as provided for in 32-2-828, whether or not the branch is to be located within or outside this state.

History: En. Sec. 38, Ch. 431, L. 2021; amd. Sec. 1, Ch. 24, L. 2023.

32-2-828. Branches. (1) A mutual association may establish and maintain branches as provided in 32-2-827 and this section. The formation and operation of a branch in this state by a mutual association organized under the laws of this state require the prior approval of the department. A mutual association organized under the laws of this state may establish, acquire, or operate a branch or loan production office outside of this state if approved by the department and if permitted by the laws of the jurisdiction where the branch or office is to be located.

(2) A branch may offer all services and conduct all business authorized to be offered or conducted by the mutual association.

(3) A mutual association authorized to do mutual association business in this state may use a satellite terminal, as defined in 32-6-103, at any location permitted by the Montana Electronic Funds Transfer Act.

(4) A mutual association located in this state may provide services for other mutual associations located in this state, whether or not those mutual associations are affiliates.

(5) With the prior approval of the appropriate federal regulator and state chartering authority, a mutual association that is not organized under the laws of this state may establish and operate a de novo branch in this state under the same terms that would apply to a mutual association organized under the laws of this state seeking approval from the department to establish and operate a de novo branch in this state.

History: En. Sec. 39, Ch. 431, L. 2021.

32-2-829. Sale of branch. Any mutual association may, with the approval of the department, buy from or sell to another mutual association, regardless of where either mutual association is located or doing business, all or substantially all of the business, assets, and liabilities of the selling mutual association's branch or branches that are physically located in this state.

History: En. Sec. 40, Ch. 431, L. 2021.

32-2-830. Loan production office — rulemaking. (1) A mutual association may:

(a) establish and maintain a loan production office only after giving notice to the department; or

(b) relocate or close a loan production office after giving notice to its customers and the department.

(2) The department may adopt rules to implement this section.

History: En. Sec. 15, Ch. 431, L. 2021.

32-2-831. Agreement of purchase and sale. (1) The selling and purchasing mutual associations shall enter into an agreement that must contain:

(a) all of the terms and conditions of the sale;

(b) proper provision for the assumption, payment, transfer, or retention of all of the liabilities of the selling mutual association as to the branch assets and business sold; and

(c) proper provision for the assumption, payment, transfer, or retention of the purchasing mutual association of all fiduciary obligations of the branch or branch business sold.

(2) The agreement for purchase and sale of a state mutual association must be authorized and approved by the department. The agreement of purchase and sale of a national savings association must be in accordance with the laws applicable to national savings associations.

History: **En. Sec. 41, Ch. 431, L. 2021.**

Part 9
Operation and Regulation

32-2-901. Mutual association advertising before issuance of charter. It is unlawful for any individual, firm, or corporation to advertise, publish, or otherwise promulgate that it is engaged in the mutual association business without first having obtained authority from the department. Any person who violates this section is subject to the penalties in 32-2-607(5).

History: **En. Sec. 42, Ch. 431, L. 2021.**

32-2-902. Prohibitions on advertising as mutual association — trade names restricted. (1) Except as provided in subsection (4), a person, firm, company, partnership, or corporation, either domestic or foreign, that is not subject to the supervision of the department and not required by the provisions of this chapter to report to the department and that has not received a certificate to do business as a mutual association from the department may not:

(a) except as for a student financial institution, as defined in 32-1-115, advertise that the person or entity is receiving or accepting money or savings for deposit, investment, or otherwise and issuing notes or certificates of deposit; or

(b) use an office sign at the place where the business is transacted that has on it an artificial or corporate name or other words indicating that:

(i) the place or office is the place or office of a mutual association;

(ii) deposits are received there or payments made on checks; or

(iii) any other form of mutual association business is transacted there.

(2) The person, firm, company, or corporation, domestic or foreign, may not use or circulate letterheads, billheads, blank notes, blank receipts, certificates, circulars, or any written or printed or partly written and partly printed papers that contain an artificial or corporate name or other words indicating that the business is the business of a mutual association.

(3) The person, firm, company, partnership, or corporation or any agent of a foreign corporation not having an established place of business in this state may not solicit or receive deposits or transact business in the manner of a mutual association or in a manner that leads the public to believe that its business is that of a mutual association.

(4) (a) A person, firm, company, partnership, or corporation, domestic or foreign, except for a student financial institution, as defined in 32-1-115, that is not subject to the supervision of the department and not required by the provisions of this chapter to report to the department and that has not received from the department a certificate to do a mutual association business may not transact business under a name or title that contains the words "mutual savings and loan association", "savings and loan association", "savings and loan", "mutual association", "mutual savings association", "building and loan", or "building and loan association", unless the department has granted a waiver.

(b) The department may grant a waiver to allow the use of a restricted word listed in subsection (4)(a) to a nonprofit organization if:

(i) the organization is not acting as a financial institution; and

(ii) the name used is not likely to mislead a reasonable individual into thinking that the organization is acting as a financial institution.

(5) A person, firm, company, partnership, or corporation, domestic or foreign, violating a provision of this section shall forfeit to the state $500 a day for every day or part of a day during which the violation continues.

(6) Upon suit by the department, the court may issue an injunction restraining the person, firm, company, partnership, or corporation during pendency of the action and permanently from further using those words in violation of the provisions of this section or from further transacting business in a manner that leads the public to believe that its business is that of a mutual association and may enter any other order or decree as equity and justice require.

History: **En. Sec. 43, Ch. 431, L. 2021.**

32-2-903. Penalty for transacting business without certificate. (1) A person, firm, company, partnership, or corporation, domestic or foreign, advertising that the person or entity is receiving or accepting money or savings for deposit, investment, or otherwise and issuing notes or certificates of deposit for them or advertising that the person or entity is transacting the business of a mutual association or making use of an office sign at the place where the business is transacted, having on it an artificial or corporate name or other words indicating that the place or office is the place or office of a mutual association, or that deposits are received there or payments made on check or that interest is paid on deposits or that certificates of deposit, with or without interest, are being issued or that any other form of mutual association business is transacted, and a person, firm, company, partnership, or corporation, domestic or foreign, using or circulating any letterheads, billheads, blank notes, blank receipts, certificates, or circulars or any written or printed or partly written and partly printed paper whatever, having on it an artificial or corporate name or advertising that the business is the business of a mutual association, must have the proper capital set aside for the purpose of transacting that business and must have received form the department, as provided in this chapter, a certificate to do a mutual association business.

(2) A person who violates any provision of this section is subject to the penalties set forth in 32-2-607(5).

(3) Upon action brought by the department, the court may issue an injunction restraining a person, firm, company, partnership, or corporation from further violating any provision of this section and may enter a further order or decree as equality and justice require.

(4) A person, firm, company, partnership, or corporation doing any of the things or transacting any of the business defined in this section shall transact that business according to the provisions of this chapter, and the department may examine the accounts, books, papers, cash, and credits of that person, firm, company, partnership, or corporation, domestic or foreign, in order to ascertain whether that person, firm, company, partnership, or corporation has violated or is violating any provisions of this section.

History: En. Sec. 44, Ch. 431, L. 2021.

32-2-904. Mutual associations — powers and duties. (1) A mutual association may:

(a) act as fiscal agent for and receive deposits from the federal government, this state, or any agency or political subdivision of the federal government or this state;

(b) sue and be sued, complain, and defend in any court of law or equity;

(c) have a corporate seal, affixed by imprint, facsimile, or otherwise;

(d) appoint officers and agents as its business requires and allow them suitable compensation;

(e) adopt bylaws not inconsistent with the laws of Montana and the rules adopted under the laws of Montana;

(f) raise capital, which must be unlimited, by accepting payments on savings, demand, or other accounts, as are authorized by statute and rule, and the holders of the accounts or other accounts must, to the extent as may be provided by such rules and regulations, be members of the association and must have the voting rights and other rights as are provided;

(g) issue notes, bonds, debentures or other obligations, or securities, provided by or under any provision of state statute as from time to time is in effect;

(h) provide for redemption of insured accounts;

(i) borrow money without limitation and pledge and otherwise encumber any of its assets to secure its debts;

(j) lend and otherwise invest its funds as authorized by statute and rules;

(k) wind up and dissolve, merge, consolidate, convert, or reorganize;

(l) purchase, hold, and convey real estate and personal property consistent with its objectives, purposes, and powers;

(m) mortgage or lease any real estate and personal property and take the property by gift, devise, or bequest; and

(n) exercise all powers conferred by law.

(2) In addition to the powers listed in subsection (1), the mutual association may have power to do all things reasonably incident to the accomplishment of its express objects and the performance of its express powers.

History: En. Sec. 45, Ch. 431, L. 2021.

32-2-905. Extent that assets may be pledged. No mutual association, mutual association employee, or mutual association officer, except as otherwise authorized by law, may pledge or hypothecate as collateral security for money borrowed its assets in a ratio exceeding 1½ times the amount borrowed, except as otherwise authorized in writing by the department.

History: En. Sec. 46, Ch. 431, L. 2021.

32-2-906. Issuance of capital certificates. A mutual association may issue mutual capital certificates as allowed by federal law.

History: En. Sec. 47, Ch. 431, L. 2021.

32-2-907. No certificate of deposit to be issued for borrowed money. A mutual association may not issue its certificate of deposit for the purpose of borrowing money or make partial payments on any certificate of deposit.

History: En. Sec. 48, Ch. 431, L. 2021.

32-2-908. Investments of financial institutions. (1) Notwithstanding other provisions of the law, it is lawful for a mutual association operating under the laws of this state to invest the funds or money in its custody or possession, eligible for investment, in:

(a) debentures issued by the federal housing administrator and in obligations of national mortgage associations; and

(b) United States government obligations, either directly or in the form of securities of or other interests in an open-end or closed-end management type investment company or investment trust registered under the Investment Company Act of 1940, 15 U.S.C. 80a-1 through 80a-64, as amended, if:

(i) the portfolio of the investment company or investment trust is limited to United States government obligations and repurchase agreements fully collateralized by United States government obligations; and

(ii) the investment company or investment trust takes delivery of the collateral for any repurchase agreement, either directly or through an authorized custodian.

(2) The department shall publish a list of the permissible type of investments in United States government obligations as provided in subsection (1).

History: En. Sec. 49, Ch. 431, L. 2021.

32-2-909. Insurance activities — exemption — rulemaking. (1) A mutual association may:

(a) except for title insurance, sell insurance of all types, including annuities, credit life insurance, and disability insurance; and

(b) act as an insurance producer, adjuster, consultant, or administrator as defined in Title 33, chapter 17.

(2) A mutual association that engages in insurance activities authorized in subsection (1) is subject to the provisions of Title 33.

(3) A mutual association may, upon application to and approval by the department pursuant to 32-2-824, offer debt cancellation and suspension programs. Debt cancellation or suspension programs offered pursuant to this subsection are not insurance products subject to the provisions of Title 33. The department shall adopt rules to implement this subsection that must be substantially equivalent to or more stringent than federal laws, regulations, and regulatory guidelines that are applicable to debt cancellation or suspension programs offered by federal savings associations.

History: En. Sec. 50, Ch. 431, L. 2021.

32-2-910. Authority of state mutual associations to make real estate loans — borrower insurance requirements. (1) A state mutual association has the same authority to make loans on real estate that is given by acts of congress or the federal reserve system to federal savings associations.

(2) A mutual association that is subject to this section may not require a borrower, as a condition of obtaining or maintaining a loan secured by real property, to provide insurance on improvements to real property in an amount that exceeds the reasonable replacement value of the improvements.

History: En. Sec. 51, Ch. 431, L. 2021.

32-2-911. Investment in certain securities — rulemaking. (1) A mutual association may purchase, sell, underwrite, and hold investment securities that are obligations in the form of bonds, notes, or debentures, as provided in rules adopted by the department. In addition, unless limited by the department by rule, a mutual association may purchase, sell, underwrite, and hold those investment securities that are derivative transactions that federal savings associations are expressly authorized to purchase, sell, underwrite, and hold. A mutual association may hold without limit investment securities that are general obligations of the United States, obligations that are guaranteed fully as to principal and interest by the United States, or general obligations of any state.

(2) The department may adopt rules to implement this section.

History: En. Sec. 52, Ch. 431, L. 2021.

32-2-912. Mutual associations authorized to obtain insurance and make loans when approved by federal housing administrator. Notwithstanding any other provisions of the law of this state restricting the amount of any loan in relation to the value of the real estate or restricting the term of any such loan or restricting the rate of such loan, it is lawful for any mutual association that has been approved as a mortgagee by the federal housing administrator to obtain insurance and to make loans secured by real estate as the federal housing administrator insures or makes a commitment to insure.

History: En. Sec. 53, Ch. 431, L. 2021.

32-2-913. Federal housing securities eligible collateral. If collateral must or may be furnished by any state mutual association as security for the deposit of any funds and the collateral must or may be deposited with any official of the state pursuant to state law, mortgages insured and debentures issued by the federal housing administrator are considered eligible collateral for these purposes.

History: En. Sec. 54, Ch. 431, L. 2021.

32-2-914. Acceptance and issuance of drafts — rulemaking. (1) A mutual association organized and existing under state law may accept for payment at a future date drafts drawn on it by its customers authorizing the holders of the drafts to draw drafts on it or its correspondents at sight or on time of the total amount of drafts accepted for any one person, firm, or corporation that does not at any one time exceed 20% of the capital of the accepting or issuing financial institution.

(2) The department may adopt rules to implement this section.

History: En. Sec. 55, Ch. 431, L. 2021.

32-2-915. Mutual association's responsibility to provide notice when funds become available for withdrawal. (1) A mutual association shall provide clear and conspicuous written notice of the time periods and exceptions to the periods concerning when funds become available for withdrawal as of right on deposit by check or similar instrument in the customer's deposit account. The notice must state the cutoff hour, if any, fixed by the mutual association after which an item is treated as being received at the opening of the next business day.

(2) This notice must be:

(a) provided to a potential customer prior to opening a deposit account; and

(b) posted in a conspicuous manner at each financial institution, automated teller machine location, and other device that accepts deposits.

(3) A deposit slip, envelope, or any other printed form furnished by the mutual association for use in connection with deposits must contain the following notice, printed in a conspicuous manner: "Your deposit may not be available for immediate withdrawal. Consult posted notices for further information."

History: En. Sec. 56, Ch. 431, L. 2021.

32-2-916. Certified checks. (1) Whenever a check drawn on a mutual association is certified by any officer or employee of the mutual association, the amount of the check must be immediately charged against the account of the person, firm, or corporation drawing the check.

(2) It is unlawful for an officer or employee of a mutual association to certify a check drawn on the mutual association, unless at the time the check is certified the person, firm, or

corporation drawing the check has on deposit with the mutual association an amount of money subject to the payment of the check equal to the amount specified in the check.

(3) An officer or employee who willfully violates the provisions of this section, reports to any device, or receives any fictitious obligation, directly or indirectly, in order to evade the provisions of this section is subject to the penalties set forth in 32-2-607(5).

History: En. Sec. 57, Ch. 431, L. 2021.

32-2-917. Deposit in name of minor. Whenever a deposit is made in a mutual association by or in the name of a minor, the deposit must be held for the exclusive right and benefit of the minor and free from the control or lien of all other persons, except creditors, and must be paid, with any interest due, to the person in whose name the deposit was made. The receipt of the minor is a sufficient release or discharge for the deposit to the mutual association.

History: En. Sec. 58, Ch. 431, L. 2021.

32-2-918. Demand or time deposits. Demand deposits, within the meaning of this chapter, comprise all deposits payable within 7 days and all savings accounts and certificates of deposit that are subject to not less than 7 days' notice before payment.

History: En. Sec. 59, Ch. 431, L. 2021.

32-2-919. Safe deposit department. A mutual association may conduct a safe deposit department. The liability of any mutual association for the safekeeping and protection of the contents of safety deposit boxes is determined by the contract endorsed on the receipt delivered to the renter of a box at the time of the rental. However, the obligation of the mutual association is limited to the exercise of ordinary diligence and care to protect the contents of the box from loss or damage by fire, theft, or other causes.

History: En. Sec. 60, Ch. 431, L. 2021.

32-2-920. Giving security for deposit prohibited — exceptions. (1) It is unlawful for a mutual association to pledge, mortgage, or hypothecate to a depositor any of its real or personal property as security for a deposit, and any pledge, mortgage, or hypothecation made in violation of this section is unenforceable.

(2) This section does not apply to deposits of the money of the United States, public funds deposited in accordance with the provision of a depository act of this state or the United States, or bankruptcy estate funds or deposits, including deposits of receivers or trustees in bankruptcy, deposited under the discretion and supervision of a court of record of Montana or of the United States.

History: En. Sec. 61, Ch. 431, L. 2021.

32-2-921. Payments to foreign administrator. A mutual association doing business in this state may pay any money remaining to the credit of a deceased depositor or deliver any personal property in its possession belonging to the deceased depositor to an administrator or executor of the depositor duly appointed and qualified in another state, provided that no demand has been previously made by an administrator or executor appointed in any county of this state and the payment discharges the mutual association to make the same from its liability on account of the deposit.

History: En. Sec. 62, Ch. 431, L. 2021.

32-2-922. Calculation of profits. Interest or commissions unpaid, although due or accrued, on debts owing to any mutual association may not be included in calculation of its profits, unless the mutual association keeps its books on a complete accrual basis. A mutual association that keeps it books on a complete accrual basis shall show on its books accrued interest receivable on notes, bonds, and other investments, unless the accrued interest is past due, and shall carry on its books accrued interest, taxes, and expenses payable.

History: En. Sec. 63, Ch. 431, L. 2021.

32-2-923. Past-due and doubtful paper. A savings association carrying any bad debt or a debt of doubtful value as an asset shall, upon the request or demand of the department, collect the debt, put in in good bankable condition, or charge it out of its books.

History: En. Sec. 64, Ch. 431, L. 2021.

32-2-924. Reserve requirements. (1) A mutual association shall maintain at all times a reserve of that percentage of its deposit liabilities as required by the appropriate federal regulator.

(2) The department may establish reserve requirements if the federal regulator discontinues reserve requirements.

(3) A mutual association whose reserve drops below the legal requirements shall report the matter to the department immediately and as often as the department asks for a report.

(4) When the reserve of a mutual association falls below the legal requirements, the mutual association may not increase its loans or discounts except by discounting or purchasing bill of exchange payable at sight or on demand, and the department shall notify a mutual association whose reserve is below the amount required to make good the reserve.

(5) In arriving at deposit liabilities with regard to mutual association deposits, the net balance of amounts due to and from other financial institutions must be used as the basis for ascertaining the deposit liability to mutual associations against which reserves are carried.

History: **En. Sec. 65, Ch. 431, L. 2021.**

32-2-925. Limitations on loans — rulemaking. (1) The total loans or extensions of credit to a person, partnership, or corporation by a mutual association, including loans to a partnership and to the members of the partnership, may not exceed 15% of the mutual association's capital, plus an additional 10% of the mutual association's capital, if the amount that exceeds the mutual association's 15% general limit is fully secured by readily marketable collateral, as defined in 12 C.F.R. 32.2(v). To qualify for the additional 10% limit, the mutual association must perfect a security interest in the collateral under applicable law and the collateral must have a current market value at all times of at least 100% of the amount of the loan or extension of credit that exceeds the mutual association's 15% general limit.

(2) To the extent specified in regulations of the office of the comptroller of the currency, a mutual association may invest in, sell, or otherwise deal in the following loans and other investments without percentage of assets limitation:

(a) account loans — loans on the security of its savings accounts and loans specifically related to transaction accounts;

(b) residential real property loans — loans on the security of liens on residential real property;

(c) United States government securities — investments in obligations of, or fully guaranteed as to principal interest by, the United States;

(d) federal home loan bank and federal national mortgage — investments in the stock or bonds of a federal home loan bank or in the stock of the federal national mortgage association;

(e) federal home loan mortgage corporation instruments — investments in mortgages, obligations, or other securities that are or have been sold by the federal home loan mortgage corporation pursuant to section 305 or 306 of the federal home loan mortgage corporation act; and

(f) other government securities — investments in obligations, participations, securities, or other instruments issued by or fully guaranteed as to principal and interest by the federal national mortgage association, the student loan marketing association, the government national mortgage association, or any agency of the United States. A savings association may issue and sell securities that are guaranteed pursuant to section 306(g) of the National Housing Act.

(3) The commissioner may adopt rules to implement this section.

History: **En. Sec. 66, Ch. 431, L. 2021.**

32-2-926 through 32-2-929 reserved.

32-2-930. Bonding of employees. (1) The board of directors of a mutual association shall require bonding for all officers and employees of the mutual association whose duty includes the handling of money, notes, bonds, credits, and cash items and whose duties include bookkeeping or the making of entries in relation to the business of the mutual association and its customers.

(2) The board of directors shall, by order entered on the minute books of the board, designate the officers and employees to be bonded and the amount of bonds to be given. Action related to the personnel, the amount of bonds, and the surety company or sureties is subject to approval by the department, and the bonds must be in a form provided or approved by the department.

(3) The bonds must be approved by the president of the mutual association, and the president's or executive officer's action must be reported to the board of directors.

(4) All bonds required by this section must be kept in the custody of the mutual association subject to inspection by examiners from the department. However, as far as possible, they may not be placed in the custody of the officer or employee for whom the bond is given.

History: **En. Sec. 67, Ch. 431, L. 2021.**

32-2-931. Persons previously convicted — rulemaking. (1) Unless the commissioner provides written consent:

(a) a person who has been convicted of a criminal offense involving dishonesty or a breach of trust or money laundering or who has agreed to enter into a pretrial diversion or similar program in connection with a prosecution for such an offense may not:

(i) become or continue as an institution-affiliated party with respect to any mutual association;

(ii) own or control, directly or indirectly, any mutual association; or

(iii) otherwise participate, directly or indirectly, in the conduct of the affairs of any mutual association; and

(b) a mutual association may not permit any person referred to in subsection (1)(a) to engage in any conduct or continue any relationship prohibited under subsection (1)(a).

(2) A person who knowingly violates subsection (1)(a) is subject to the penalties in 32-2-607(5).

(3) The commissioner may adopt rules to implement this section.

History: **En. Sec. 68, Ch. 431, L. 2021.**

32-2-932. Sale of securities by officer to mutual association. (1) A director, officer, or employee of a mutual association may not, directly or indirectly, for the person's account, for the person, or as the partner or agent of others sell or transfer or cause to be sold or transferred to the mutual association of which the person is a director or officer any note or bond secured by any mortgage or trust deed on real estate or any contract arising from the sale of real estate, in which the director, officer, or employee is personally or financially interested, without a vote of the majority of the board of the mutual association, duly noted on the minutes of the meeting at which the transaction is decided on. The minutes must be signed by a majority of the board.

(2) Any director, officer, or employee of any mutual association who knowingly violates or consents to the violation of this provision is subject to the penalties in 32-2-607(5).

History: **En. Sec. 69, Ch. 431, L. 2021.**

32-2-933. Real estate that mutual associations may purchase, hold, or convey. (1) A mutual association organized under the provisions of this chapter may purchase, hold, or convey real estate that:

(a) is for its accommodation in the transaction of its business, but the mutual association may not invest an amount exceeding 100% of its paid-up capital in the lot and building in which the business of the company is or is projected to be carried on, furniture, equipment and fixtures, vaults and safety vaults, and boxes necessary or proper to carry on its mutual association business if property held for future use as a mutual association office site is held pursuant to a detailed written business plan formally adopted by the directors of the mutual association;

(b) is mortgaged to in good faith by way of security for loans previously made or money due to the mutual association;

(c) is conveyed to the mutual association in satisfaction of debts previously contracted in the course of its business; or

(d) it purchases at sales under judgments, decrees, or mortgages held by the mutual association.

(2) The detailed written business plan required by subsection (1)(a) must include information outlining the manner in which the acquired real estate will be developed for future use as a mutual association office site, including but not limited to the costs of projected construction, furniture, and equipment and fixtures.

History: **En. Sec. 70, Ch. 431, L. 2021.**

32-2-934. Purchase of obligation of mutual association by officer. A director, officer, agent, or other employee of a mutual association may not, directly or indirectly for the person's own benefit, purchase, sell, or be interested in the purchase or sale of any obligation of the mutual association or of any assets of the mutual association for a sum less than the amount that appears on the face of the obligation or obligations purchased or sold. A person violating the provisions of this section shall, in addition to the general penalties of this chapter, forfeit to the state twice the nominal amount or face value of the obligations or assets purchased or sold.

History: En. Sec. 71, Ch. 431, L. 2021.

32-2-935. Fraud by director, officer, agent, or employee. A director, executive officer, agent, or employee of a mutual association is guilty of a felony if that person:

(1) knowingly receives or takes possession of any mutual association property, except in payment for a just demand, and with intent to defraud:

(a) fails to make or fails to cause or direct to be made a full and true entry of the receipt or possession in its books and account; or

(b) concurs in failing to make any material entry in its books and account;

(2) knowingly concurs in making or publishing any written report, exhibit, or statement of its affairs or pecuniary condition containing any material statement that is false; or

(3) having the custody of control of its books, willfully refuses or neglects to make a proper entry in the books of that mutual association as required by law, to exhibit the books, or to allow the books to be inspected and extracts to be taken from them by the department.

History: En. Sec. 72, Ch. 431, L. 2021.

32-2-936. Removal of directors, officers, or employees — hearing. (1) A director, officer, or employee of a mutual association who is found by the department, after examination, to be negligent, dishonest, reckless, or incompetent or to have violated 32-2-821, 32-2-935, 32-2-938, or 32-2-939 must be removed from office by the board of directors of the mutual association on the written order of the department. If the directors neglect or refuse to remove the director, officer, or employee and any losses accrue to the mutual association by reason of the negligence, dishonesty, recklessness, or incompetency of the director, officer, or employee, the written order of the department is conclusive evidence of the negligence of the failure of the directors to act as provided in this section in any action brought against the board of directors by a depositor or creditor for recovery of losses.

(2) If the board of directors refuses to remove the director, officer, or employee in response to an order of the department, the board of directors may file a request for hearing pursuant to the Montana Administrative Procedure Act.

History: En. Sec. 73, Ch. 431, L. 2021.

32-2-937. Penalty for unlawful hypothecation of property received. An officer or employee of a mutual association doing business in this state who, except in the manner authorized by law or the contract of the parties, pledges or in any way alienates any notes, stocks, bonds, mortgages, securities, or any other property coming into the officer's or employee's hands or into the possession of the mutual association as collateral, for safekeeping or in any other manner, and to which the mutual association has not acquitted full title, is guilty of theft and upon conviction must be punished as for other felonies.

History: En. Sec. 74, Ch. 431, L. 2021.

32-2-938. Concealing actions from directors. An officer or employee of a mutual association who intentionally conceals from the directors of the association, or from a committee of the mutual association when the directors have delegated authority, any discount or loan made by the corporation or from its assets between the regular meetings of its board of directors or committee, the purchase of any security, the sale of any of its securities, or any guarantee, repurchase agreement, or any other agreement through which the corporation is obligated, during the same period, is subject to the penalties set forth in 32-2-607(5).

History: En. Sec. 75, Ch. 431, L. 2021.

32-2-939. Theft of funds by directors, officers, or employees. A director, officer, or employee of a mutual association who fraudulently appropriates or abstracts or misapplies any of the money, funds, credits, or property of the mutual association when owned by it or held in trust or who issues or puts forth any certificate of deposit, draws any order or bill of exchange, makes any acceptance, assigns any note, bond, draft, bill of exchange, mortgage, judgment, or decree with intent to injure or defraud the mutual association or any person or corporation or to deceive any officer of the mutual association, or any other person, or anyone appointed to examine the affairs of the mutual association or any other person who with like intent aids or abets any director, officer, or employee in the violation of this section is guilty of theft and upon conviction shall be imprisoned in the state prison for a period not to exceed 20 years or be fined an amount not to exceed $50,000, or both.

History: **En. Sec. 76, Ch. 431, L. 2021.**

32-2-940. False statement to obtain loan. A person who makes a statement, knowing it to be false, for the purpose of obtaining for that person or for any other person, firm, corporation, or association a loan of money from a mutual association or for the purpose of gaining an extension of time for the payment of any debt due the mutual association shall be punished by a fine of not more than $1,000 or by imprisonment in the county jail for not more than 1 year, or both.

History: **En. Sec. 77, Ch. 431, L. 2021.**

32-2-941. Mutual association holidays. In addition to emergency closings authorized by 32-2-1030 through 32-2-1034, a mutual association in the state may remain closed and refrain from doing business on those legal holidays designated in 1-1-216.

History: **En. Sec. 78, Ch. 431, L. 2021.**

32-2-942. Transaction on holiday. No law of this state may affect the validity of, or render void or voidable, the payment, certification, or acceptance of a check or other negotiable instrument or any other transaction by a mutual association in this state because it was done or performed during any time other than regular banking hours or on a legal holiday. A mutual association in this state, which by law or custom is entitled to close at 12 noon on any Saturday or for the whole or part of any legal holiday, may not be compelled to remain open for transaction of business or to perform any of the acts or transactions in this section on any Saturday after 12 noon or any legal holiday except at its option.

History: **En. Sec. 79, Ch. 431, L. 2021.**

32-2-943. Closing on Saturdays authorized — Saturday treated as holiday. A mutual association and a federal savings association incorporated or organized under the laws of the United States or a federal reserve bank may, at its election, remain closed and refrain from the transaction of business on Saturdays. Any Saturday on which a mutual association remains closed is, with respect to the mutual association, a holiday and not a business day. Any act authorized, required, or permitted to be performed on a Saturday at or by or with respect to a mutual association, including any federal savings association or federal reserve bank, may be performed on the next succeeding business days, and no liability or loss of any rights of any kind will result from such closing on Saturday or from the nonopening of any mutual association for the transaction of business on any Saturday under the authority of 32-2-943 through 32-2-945.

History: **En. Sec. 80, Ch. 431, L. 2021.**

32-2-944. Mutual association hours and business days. A mutual association may provide for its business hours or business days by giving reasonable notice to the public and providing a copy of the notice to the department.

History: **En. Sec. 81, Ch. 431, L. 2021.**

32-2-945. Interest payable at mutual association on Saturday — how paid. When, by the terms of any note or obligation, interest is payable to a mutual association on any Saturday on which a mutual association is closed pursuant to the authority of 32-2-943 through 32-2-945, interest payable to the mutual association on that Saturday may be paid in the amount due on that Saturday on the next succeeding business day with the same effect as if paid to the mutual association on Saturday.

History: **En. Sec. 82, Ch. 431, L. 2021.**

32-2-946 through 32-2-949 reserved.

32-2-950. Destruction of records — rulemaking. (1) Mutual associations are required to preserve or keep their records of customer accounts for at least 8 years after January 1 of the year following the time that the records are made. However, records showing unpaid balances in favor of depositors of a mutual association may not be destroyed. Liability may not accrue against a mutual association destroying any records, except records for which destruction is forbidden by this section, after the expiration of the time provided in this section.

(2) The department shall adopt rules providing for retention schedules for mutual association records other than those records listed in subsection (1).

History: **En. Sec. 83, Ch. 431, L. 2021.**

32-2-951. Definitions — reproductions of mutual association records — admissibility in evidence — cost recovery. (1) For the purposes of this section, the following definitions apply:

(a) "Electronic storage" or "electronically stored" means the recording, storage, retention, maintenance, and reproduction of documents using microfiche, data processing, computers, or other electronic process that correctly and legibly stores and reproduces documents.

(b) "Mutual association records" includes any document, paper, letter, book, map, photograph, sound or video recording, magnetic tape, electronic storage medium, or other information-recording medium used in a mutual association's normal course of business.

(2) (a) A photographic, photostatic, miniature photographic copy, or reproduction of any kind, including electronic or computer-generated data that has been electronically stored and is capable of being converted into written form, must be considered an original record for all purposes and must be treated as an original record in all courts and administrative agencies for the purposes of admissibility in evidence.

(b) A facsimile, exemplification, or certified copy of any reproduction referred to in subsection (2)(a) must, for all purposes, be considered a facsimile, exemplification, or certified copy of the original record.

(3) Except as provided in subsection (7), mutual associations are authorized to make, at any time, photographic or photostatic copies or microfilm reproductions of any records or documents, including photographic enlargements and prints of microfilms, to be preserved, stored, used, and employed in carrying out business.

(4) In an action or proceeding in which mutual association records may be called in question or be demanded of a mutual association or any officer or employee of a mutual association, a showing that the records have been destroyed in the regular course of business is a sufficient excuse for the failure to produce the records.

(5) Upon the showing required in subsection (4), secondary evidence of the form, text, and contents of the original records, including photostatic, photographic, or microfilm reproductions, photographic enlargements, and prints of microfilm reproductions, when made in the regular course of business, is admissible in evidence in any court of competent jurisdiction or in any administrative proceeding.

(6) Any photostatic, photographic, or microfilm reproductions, including enlargements of the microfilm reproductions, made in the regular course of business of any original files, records, books, cards, tickets, deposit slips, or memoranda that were in existence on July 1, 1951, are admissible in evidence as proof of the form, text, and content of the originals that were destroyed in the regular course of business.

(7) A mutual association may, as a condition of providing mutual association records to a third party in response to a subpoena or another legal procedure or request, charge and collect the actual costs incurred in locating, reproducing, and providing the mutual association records.

History: **En. Sec. 84, Ch. 431, L. 2021.**

32-2-952. Admissibility of copies in evidence — exception when original available. Any photostatic, photographic, or microfilm reproductions, including enlargements, of any original records or files of a mutual association, whether in the form of an entry or entries in a book or any other form of record, are admissible in evidence in any court of competent jurisdiction in proof of an act, transaction, occurrence, or event if shown to be made in the regular course of business of the mutual association. Nothing in 32-2-950 through 32-2-954 may be construed to authorize the use of secondary evidence in administrative or court proceedings if original records are in existence and available for use in accord with the rules of evidence.

History: **En. Sec. 85, Ch. 431, L. 2021.**

32-2-953. Destruction or reproduction. Destruction in the regular course of business includes destruction at any time after making reproductions. Reproductions made in the regular course of business include reproductions made at any time prior to the destruction of the original, in each case, if done in good faith and without intent to defraud.

History: **En. Sec. 86, Ch. 431, L. 2021.**

32-2-954. Application. The provisions of 32-2-950 through 32-2-954 are applicable to all records in existence on February 23, 1951, and to all records originating after that date and apply to all mutual associations organized under the laws of the state and to all federal savings associations located in the state, as far as applicable to the federal savings associations.

History: **En. Sec. 87, Ch. 431, L. 2021.**

Part 10

Dissolution, Closing, and Liquidation

32-2-1001. Dissolution and disincorporation. (1) Mutual associations may be dissolved in the manner provided by the laws of this state applicable to the dissolution of other corporations. However, a mutual association may, on a vote of two-thirds of its members at a special meeting called for that purpose in accordance with its bylaws, voluntarily quit business and liquidate upon the payment of its debts or upon agreement with all of its creditors to a plan of liquidation.

(2) A mutual association that wishes to voluntarily liquidate shall apply to the department for permission to liquidate and, in addition to complying with the laws of this state governing the liquidation of corporations, shall comply in all respects with the requirements or rules of the department governing voluntary dissolution.

(3) The board of directors of a mutual association whose members have voted to place it in voluntary liquidation shall appoint a liquidating agent to wind up the affairs of the mutual association. The liquidating agent, on authority of the board of directors, may execute deeds for the transfer of real property and do all things necessary to carry out the proper liquidation of the mutual association.

(4) Nothing in this section prevents the department from taking charge at any time when in its opinion the interest of creditors is not being protected. The decision of the department in these matters is controlling.

History: **En. Sec. 88, Ch. 431, L. 2021.**

32-2-1002. Grounds for closing mutual association. (1) If it appears to the department that any of the following situations have occurred, the department may, in its discretion, close the mutual association and take possession of all of the books, records, assets, and business of every description of the mutual association and hold and retain possession of them until the mutual association is authorized by the department to resume business or until its affairs are liquidated as provided in this chapter, and it shall do so in cases in which a mutual association comes into its possession voluntarily or in the manner provided by law. The situations are as follows:

(a) a mutual association has willfully violated its charter or a law of this state;

(b) a mutual association has willfully violated a general rule of the department, made in accordance with law;

(c) the capital of a mutual association is impaired or for any reason is below the amount required by state or federal law and has not been made good after notice, as provided by law, or, without that notice, in the event a majority of the board of directors of the mutual association notifies the department in writing that the impairment cannot be made good;

(d) a mutual association cannot meet or has failed to meet its liabilities as they become due in the regular course of business;

(e) a mutual association's reserve has fallen below the amount required by state or federal law and it has failed to make good that reserve within 30 days after being requested to do so by the department, without that notice, if a majority of the directors, in writing, notifies the department that the reserve cannot be made good within 30 days or if is continually allowing its reserve to fall below the required amount;

(f) a mutual association is conducting business in an unsafe and unauthorized manner or is in an unsafe and unsound condition;

(g) a mutual association has refused to submit its papers, books, and concerns to the inspection of the department; or

(h) an officer of a mutual association has refused to be examined under oath regarding the affairs, business, or concerns of any mutual association as they relate to solvency or matters having to do with the supervision by the department.

(2) The powers and authority conferred on the department by this section, except in cases of voluntary surrender, are discretionary and not mandatory. As long as the department acts in good faith, the department and its employees and agents may not be held liable civilly or criminally or on their official bonds for action taken under this section or for any failure to act under it.

History: **En. Sec. 89, Ch. 431, L. 2021.**

32-2-1003. When mutual association insolvent. A mutual association is insolvent within the meaning of this chapter when its capital is absorbed in losses and the remaining assets are not sufficient to pay and discharge its contracts, debts, and engagements.

History: **En. Sec. 90, Ch. 431, L. 2021.**

32-2-1004. Deposits in insolvent mutual associations. (1) Except as otherwise provided by the Uniform Commercial Code, whenever a mutual association is insolvent in the manner set forth in this chapter, the mutual association may not accept or receive on deposit any money, financial bills or notes, United States treasury notes or currency, or other notes, bills, or drafts circulating as money or currency or transact any other business in connection with its operations, except as trustee for the depositors and parties transacting business with them, and it shall keep all such deposits of money, bills or notes, United States treasury notes or currency, or other notes, bills, or drafts circulating as money or currency separate and apart from the general assets of the mutual association from and after the date of the accrual of the insolvency. When the impairment or insolvency has been made good, the deposits received in trust may be transferred to the general assets of the mutual association on and by written consent of the department.

(2) If the insolvency is not made good, then all trust deposits must be returned to the depositors making them.

(3) An officer, director, cashier, manager, member, partner, or managing partner who knowingly accepts or receives, is accessory to, or permits or connives at the receiving or accepting of the trust deposits, except in the manner set forth in this section, is guilty of a felony and upon conviction shall be punished by a fine not exceeding $10,000 or imprisonment in the state prison for a term not exceeding 5 years, or both.

History: **En. Sec. 91, Ch. 431, L. 2021.**

32-2-1005. Penalty for receiving deposits when insolvent or for making false statement. (1) Any officer, agent, or clerk of a mutual association, knowing the mutual association to be insolvent, who receives money, bank bills, notes of the United States, or currency or other bills or drafts circulating as money or currency, except in the manner set forth in 32-2-1004, who subscribes or makes any false statements or entries in the books of the mutual association, who knowingly subscribes or exhibits any false paper with the intent to deceive any person authorized to examine as to the condition of the mutual association, or who willfully subscribes or makes false reports is subject to the penalties set forth in 32-2-607(5).

(2) Any person or the members of any partnership or mutual association who willfully or knowingly receive deposits, money, or commercial papers circulating as money, when the person, partnership, or mutual association is insolvent, or who subscribe or make any false statement or entries in the books of any such mutual association, who knowingly subscribe or exhibit any false papers with the intention of deceiving any person authorized to examine the condition of any mutual association provided for in this chapter, or who willfully subscribe or make false reports to the department are subject to the penalties set forth in 32-2-607(5).

History: **En. Sec. 92, Ch. 431, L. 2021.**

32-2-1006. Power of closed mutual associations to borrow money from governmental agencies. (1) Except as provided in subsection (2), after applying to and obtaining the approval of the department and the district court of the county in which the mutual association is located, the liquidating agents of closed mutual associations may borrow money from an agency of the federal government on behalf of mutual associations closed and in liquidation. As security for the loan, the liquidating agent may pledge or mortgage assets and properties for the purpose of paying depositors or creditors in part or in full.

(2) If the federal deposit insurance corporation is appointed as the liquidating agent, the reporting and district court approval requirements of subsection (1) do not apply.

History: **En. Sec. 93, Ch. 431, L. 2021.**

32-2-1007. Corporate existence — cessation. (1) The charters and the corporate existence of mutual associations cease automatically and become nonexistent upon the completion of liquidation of the affairs of the mutual association, whether accomplished voluntarily or through a legal process.

(2) For the purposes of this section, a mutual association's affairs are considered liquidated and completed when all of its property of every kind has been sold or applied toward the payment of its obligations and the corporation is left without property in existence or in reasonable expectancy.

History: **En. Sec. 94, Ch. 431, L. 2021.**

32-2-1008. Taxes on mutual associations that have ceased to do business. Whenever a mutual association ceases to do business as a mutual association, taxes may not be levied or collected in accordance with the laws governing the assessment of mutual associations but its property must be assessed in accordance with the laws governing the assessment of similar property of private corporations.

History: **En. Sec. 95, Ch. 431, L. 2021.**

32-2-1009. Penalty for maliciously declaring mutual association insolvent. If, as a result of malice or for personal gain, an employee or agent of the department declares a mutual association insolvent, the employee or agent forfeits the employee's or agent's office.

History: **En. Sec. 96, Ch. 431, L. 2021.**

32-2-1010. Resumption after closing. After the department has taken possession of a mutual association, it may permit the mutual association to resume business following conditions approved by the department.

History: **En. Sec. 97, Ch. 431, L. 2021.**

32-2-1011. Powers of department on closing mutual association — court proceedings. (1) After taking the assets and business of a mutual association into its possession, the department is authorized to collect all money due to the mutual association and to do other acts necessary to conserve the mutual association's assets and business. The department shall proceed to liquidate the affairs of the mutual association.

(2) The department may, except as limited by the terms of this chapter, do any acts necessary or desirable for the protection of the property and assets of the mutual association, the speedy and economical liquidation of the assets and affairs of the mutual association, the payment of creditors, or the reopening and resumption of business when that is practicable or desirable.

(3) The department may institute, in its own name or in the name of the mutual association, legal proceedings it considers expedient for the purposes of subsection (1).

(4) (a) By applying to the district court of the county in which the mutual association is located or to the judge of that court, the department may obtain an order to sell, compromise, or compound any bad or doubtful debt or claim and to sell and dispose of any assets. The sale may be made to officers, directors, or others interested in the mutual association on the consent of the court.

(b) In the court proceedings, the mutual association must be made a party by notice issued on order of the court or judge, in place of summons, and served on an officer of the mutual association if there is an officer in the county.

(5) If the federal deposit insurance corporation is appointed as the liquidating agent, subsection (4) does not apply.

History: **En. Sec. 98, Ch. 431, L. 2021.**

32-2-1012. Recourse of aggrieved mutual association — injunction. (1) A mutual association aggrieved by the action of the department in taking possession of its assets or closing its doors may, within 14 days after possession has been taken, apply to the district court of the county in which its principal office of business is located to enjoin further proceedings by the department.

(2) The court, after notifying the department to appear at a specified time and place to show cause why further proceedings should not be enjoined and after hearing the allegations and proofs of the parties and determining facts, may on the merits dismiss the application or enjoin the department from further proceeding and direct it to surrender the business and assets of the mutual association.

(3) The application for injunction may be heard at any time after 5 days' notice from the time of service on the department, in the discretion of the court, or at any time prior to that time by the consent of the department.

(4) Application must be made on the verified complaint of the mutual association, in the form used in civil actions, and a copy of the complaint must be served on the department with the order to show cause.

(5) The department shall, at least 2 days before the time set for hearing, file with the court and serve on counsel for the plaintiff an answer to the complaint, also in the form used in civil actions. Any questions raised by motion in other actions may be raised in the answer.

(6) On the issues raised by the complaint and answer, the court, at the time fixed for showing cause, shall try the matter on the merits by hearing the allegations and proofs of the parties and shall enter judgment, as in the trial of other civil actions.

(7) If the department makes no appearance in the time allowed, the court shall enter its default and proceed to hear the proofs of the plaintiff as in civil actions under similar circumstances and enter judgment accordingly. The judgment entered either after hearing on the merits or by default is a final judgment.

(8) During the pendency of litigation, the department shall take action in relation to the assets of the mutual association necessary to conserve them.

History: **En. Sec. 99, Ch. 431, L. 2021.**

32-2-1013. Department may retain mutual association employees — liquidating agent's salary and expenses. (1) The department may retain those officers or employees of the mutual association that it considers necessary. It shall require from the agent appointed by it and from those assistants who have charge of any of the assets of the mutual association that security for the faithful discharge of their duties as it considers proper.

(2) The salary of a liquidating agent and necessary clerical assistance and other expenses incurred by a liquidating agent must be borne equally and ratably by the mutual association or mutual associations in process of liquidation under the agent's charge in proportion to the total amount of resources of each of the mutual associations. The funds for those expenses must be raised by assessing each mutual association in ratio set forth in this section and paying those expenses directly to the persons entitled to them, without depositing any of the funds in the state treasury.

History: **En. Sec. 100, Ch. 431, L. 2021.**

32-2-1014. Compensation of agents and attorneys. (1) Except as provided in subsection (2), after notice to the mutual association and subject to approval by a district court judge of the county in which the mutual association is located, the compensation of the agents, attorneys, expert accountants, and other assistants appointed by the department and all expenses of liquidation and distribution of a mutual association whose assets and business have been taken possession of by the department must be fixed by the department. The department shall, on written request of the judge, supply semiannual statements showing the condition of the mutual association in the process of liquidation. Except in cases of emergency, the compensation paid to attorneys and expert accountants must be fixed and approved before services are rendered.

The compensation must be paid out of the funds of the mutual association in the hands of the department and are a proper charge and lien on the assets of the mutual association.

(2) If the federal deposit insurance corporation is appointed as the liquidating agent, the reporting and district court approval requirements in subsection (1) do not apply.

History: **En. Sec. 101, Ch. 431, L. 2021.**

32-2-1015. Notice to creditors of insolvent mutual association. (1) Except as provided in subsection (2), the department shall give notice by advertisement once a week for 2 successive weeks in a newspaper of general circulation in the town or city where the mutual association is located, if there is one, or in another newspaper that is published in the state and designated by the department. The notice must call on all persons who have claims against the mutual association to present them to the department or its authorized agent at a place specified in the notice and to make sworn proof, in a form to be fixed by the department, within the time specified in the notice, not less than 90 days after the date of the first publication. A copy of the notice must be mailed to all persons whose names appear as creditors on the books of the mutual association.

(2) If the federal deposit insurance corporation is appointed as the liquidating agent, the provisions of subsection (1) do not apply and notice to creditors must be given pursuant to federal law.

History: **En. Sec. 102, Ch. 431, L. 2021.**

32-2-1016. Claims — allowance and rejection. (1) Except as provided in subsection (6), the department may reject or allow all claims in whole or in part and on each claim allowed shall designate the order of its priority.

(2) If a claim is rejected or an order of priority allowed lower than that claimed, notice must be given the claimant personally or by common courier with tracking capability and an affidavit of the service of the notice, which is prima facie evidence of service, must be filed in the office of the department.

(3) The action of the department is final unless an action is brought by the claimant against the mutual association in the district court of the county in which the mutual association is located within 90 days after service. An appeal from the department's allowance may also be taken by any party in interest by serving notice on the department, stating the grounds of objection and filing an action in that court within 30 days after allowance.

(4) Within 5 days after the notice, the department shall file in the court and serve on the appellant a copy of the claim and its reasons for allowance.

(5) The court shall, after 5 days' notice of time and place of hearing on the issues raised, hear the proof of the parties and enter judgment reversing, affirming, or modifying the department's action.

(6) If the federal deposit insurance corporation is appointed as the liquidating agent, the provisions of subsections (1) through (5) do not apply and notice to creditors must be given pursuant to federal law.

History: **En. Sec. 103, Ch. 431, L. 2021.**

32-2-1017. Payment of claims. (1) Claims presented to the department prior to the expiration of the time fixed in the notice to creditors and allowed by it must be paid in the order of the priority fixed in this chapter.

(2) Those claims filed after that expiration and within 1 year of that expiration are entitled, after they have been allowed by the department, to share in the distribution of the assets of the mutual association only to the extent of the assets undistributed in the hands of the department and available for the payment of claims of their order of priority at the time claims are filed.

(3) All claims filed after the expiration of 1 year following the date fixed in the notice to creditors as the time for presentation of claims are not entitled to be allowed or paid unless all other creditors' claims of any kind have been fully paid and a surplus remains in the hands of the department and then only from that surplus.

(4) If the federal deposit insurance corporation is appointed as the liquidating agent, the times fixed in subsections (1) through (3) do not apply and claims must be filed in accordance with times fixed pursuant to federal law.

History: **En. Sec. 104, Ch. 431, L. 2021.**

32-2-1018. Claims — order of payment — priorities. (1) Except as otherwise provided by the Uniform Commercial Code, the order of payment of the debts of a mutual association liquidated by the department is as follows:

(a) the expense of liquidation, including compensation of agents, employees, and attorneys;

(b) all funds of any other mutual association in the process of liquidation by the department and placed on deposit by the department;

(c) all funds held by the mutual association in trust;

(d) debts due depositors or holders of cashier's checks, certified checks, and drafts on correspondent financial institutions or mutual associations, including protest fees paid by them on valid checks or drafts presented after closing of the mutual association, pro rata. All deposit balances of other financial institutions, mutual associations, or trust companies and all deposits of public funds of every kind except those actually placed on special deposit under the statutes providing for deposit, including those of the United States, this state, and every county, district, municipality, political subdivision, or public corporation of this state, whether secured or unsecured and whether deposited in violation of law or otherwise, are included within the terms of this subsection (1)(d) and take the same priority as debts due any other depositor. Accrued interest on savings accounts, certificates of deposit, or other interest-bearing contracts, up to the time of the closing of the mutual association, is considered as part of the debt due.

(e) interest on the classes of claims contained in subsections (1)(a) through (1)(d) without regard to the priority computed from the date of closing of the mutual association in accordance with the provisions of 25-9-205; and

(f) unliquidated claims for damages and similar claims.

(2) The department may, in its discretion, without regard to the priorities fixed in subsections (1)(c) through (1)(f) or in preference to the payment of any claims of creditors within those subsections, pay off and discharge any lien, claim, or charge against the assets or property of the mutual association in its hands and pay those sums it considers necessary for the preservation, maintenance, conservation, and protection of those assets and property and property on which the mutual association has liens by mortgage or otherwise. The department may create a fund or retain, in preference to the claim of any creditors in subsections (1)(c) through (1)(f), money for those purposes.

(3) Collateral that has been put up or pledged as security for the payment of bills payable by a mutual association or loans or discounts that have been outstanding as rediscounts of a mutual association prior to the closing of it is not available to the other creditors of the mutual association in whole or in part until the bills payable or rediscounts have been retired, after which offsets as provided in this section must be allowed.

(4) Deposits of a person, firm, or corporation in a mutual association that is in the possession of the department may be offset against any indebtedness subject to subsection (3).

History: En. Sec. 105, Ch. 431, L. 2021.

32-2-1019. Claims — partial payments — assignments. (1) At any time after taking possession of the mutual association and prior to the expiration of the period fixed for filing of claims, and if under the circumstances of the particular case it considers it expedient and safe and if it has on hand in cash sufficient funds in excess of the expenses of liquidation, the department may make pro rata distribution to any class of creditors entitled to distribution in the order of priority fixed in this chapter. The department shall make a payment to the creditors as they appear on the books and records of the mutual association and after determining the priority and basing its apportionment on the amount shown to be due by the books and records.

(2) At any time after the expiration of the date fixed for the presentation of claims against the mutual association and from time to time after that date when, in its discretion, there are sufficient funds available, the department shall, after making proper provisions for the payment of expenses of liquidation, declare and make payments to all creditors of the mutual association pro rata in the order of their priority. If, after the time fixed for presentation of claims against the mutual association has expired, it appears that a person, prior to the expiration of the period or at any other time, has been paid more than the pro rata amount due the person as compared with the amounts paid to other creditors, nothing more may be paid to that creditor until the payment made to other creditors places them on equal footing.

(3) Claims against a mutual association in process of liquidation may be assigned in whole or in part subject to the approval of the department. Assignments of claims are binding on the department only after they have been filed and allowed by the department and are subject to the payment of the assignor's liabilities to the mutual association. An assignment must be made by filing written notice, signed by the original claimant, with the department or person in charge of the mutual association. Assigned claims may not be offset against obligations due the mutual association. A check or draft drawn against a mutual association closed or taken possession of by the department, whether issued before or after closing, may not be recognized as a claim against the mutual association or as an assignment of any amount, whether protested or not protested.

History: **En. Sec. 106, Ch. 431, L. 2021.**

32-2-1020. Deposit of funds in department's hands. All funds in the hands of the department belonging to a mutual association in process of liquidation must be deposited in the department's name in those financial institutions in the state and designated by it and subject to its checks. Those funds must be preferred and protected as provided in this chapter.

History: **En. Sec. 107, Ch. 431, L. 2021.**

32-2-1021. Disposition of unclaimed funds. (1) The department shall certify to the state treasurer a complete list of funds remaining with the department that are uncalled for and that have been left with it in its official capacity in trust for depositors in and creditors of a liquidated mutual association after the funds have been held by the department for 6 months from the date of the final liquidation of the institution. Along with this certificate, the department shall transmit to the state treasurer the funds, with accumulated interest on them, that it has held in trust for 6 months. A copy of the certificate must also be filed with the state auditor, who shall make a record of it.

(2) The state treasurer shall deposit the funds and interest in the general fund.

(3) A depositor or creditor of a liquidated mutual association who has not been paid the amount standing to the person's credit as certified to the state treasurer may apply to the department for the amount due. The depositor or creditor shall make an affidavit and offer proof of identity and of the amount due. When satisfied as to the correctness of the claim and of the identity of the person, the department shall forward it to the state treasurer, who shall audit the claim and, if the claim is found to be correct, certify the claim to the department. If the department approves the claim, it shall pay the claim to the depositor or creditor.

History: **En. Sec. 108, Ch. 431, L. 2021.**

32-2-1022. Disposition of assets remaining after payment of claims. (1) (a) Except as provided in subsection (4), when the department has paid to each depositor and creditor of the mutual association whose claims have been approved and allowed as provided in this chapter the amount due on them or made satisfactory adjustment of them and has made provisions for unclaimed and unpaid deposits and disputed claims and deposits and has paid all the expenses of liquidation, it shall file a report of its administration of the trust with the clerk of the district court of the county in which the mutual association is located.

(b) If there are remaining assets on hand, the department may apply to the judge of the district court for an order authorizing it to surrender the remaining assets, together with all the stationery, correspondence, books, and records kept by the mutual association while it was a going concern, to the directors of the mutual association in office at the time of closing it, as trustees for members, or to some other person, if any, designated as trustee by a majority of the members. The report and petition must be set for hearing on notice that the court may direct.

(c) Upon hearing and approval of the report and account and the surrender of the assets as directed, the department is discharged from all further liability or responsibility in connection with the assets and affairs of the mutual association. The court may, if requested, require the trustees to give bond in an amount the court may fix, conditioned for the faithful performance of their duties.

(d) The trustee or trustees shall complete the liquidation of any remaining assets and may sell and dispose of real and personal property as rapidly as possible and shall distribute the proceeds among the members as their rights may appear or dispose of the proceeds in some other manner as the members by majority action direct.

(e) On request of a majority of the members, the court may order the department to close up the trust as provided in subsection (2).

(2) (a) If the assets of the mutual association are insufficient for making payments in full to the depositors and creditors of the mutual association, then, when the department has liquidated all available assets and disbursed them as provided by law, the department shall file a final report of its liquidation of the mutual association with the clerk of court of the county in which the mutual association is located. On notice that the court may order, the report must be set for hearing before the court and, if the report is found correct and all funds accounted for, the court shall approve it.

(b) The department may at the same time and in the report make application to the district court of the county in which the mutual association is located for an order directing the closing of the trust, and upon entry of the order closing the trust, the department is discharged from all further liability or responsibility in connection with the assets and affairs of the mutual association. The charter of the mutual association must be forfeited, and all of the stationery, correspondence, books, and records kept by the mutual association while it was a going concern and considered by the department to be of no value may be destroyed. However, correspondence or records may not be destroyed until 10 years after the date the mutual association ceases to be a going concern.

(3) On application for orders as provided in this section, the mutual association must be made a party by notice issued on order of the court or judge and served in a manner the court directs, and applications authorized by this section may be heard at any time on not less than 5 days' posted or served notice of the hearing.

(4) If the federal deposit insurance corporation is appointed as the liquidating agent, the reporting and district court approval requirements of subsections (1) through (3) do not apply.

History: **En. Sec. 109, Ch. 431, L. 2021.**

32-2-1023. Further duties of liquidating officer. (1) The liquidating officer of a mutual association may decide when the assets of a failed mutual association are not sufficient to pay the debts, contracts, engagements, and liabilities and may determine the time when and the court where necessary legal proceedings are conducted, subject to the general provisions of law governing venue and place of trial.

(2) For the purposes of this section, the term "liquidating officer" includes any person legally empowered to liquidate the business and affairs of a state mutual association, whether the liquidation is by the department or by its deputies and agents. The term also includes all receivers of state mutual associations qualified to liquidate a state mutual association under state law.

History: **En. Sec. 110, Ch. 431, L. 2021.**

32-2-1024. Department to file inventory — report required — exception. (1) Except as provided in subsection (2), the department shall, within 90 days after taking charge of an insolvent mutual association, file with the district court having jurisdiction a complete inventory of all of the property and assets of the insolvent mutual association, such as furniture, fixtures, real estate, mortgages, bonds, and notes, secured and unsecured.

(2) The department shall every 6 months, or more often if required by the court, file with the court a report showing the status of the liquidation of the mutual association, the assets that have been liquidated and collected, the amounts and manner of payments made to creditors, the manner in which claims have been handled, and the assets on hand. The report must contain other information the court requires, so that the court and the public may be apprised of the condition of the mutual association and the manner in which it is being liquidated with respect to the collection and sale of assets belonging to the mutual association and the manner in which claims are being paid. The report and account must be set for hearing on the notice the court may require and, if found to be correct, must be approved by the court.

History: **En. Sec. 111, Ch. 431, L. 2021.**

32-2-1025 through 32-2-1029 reserved.

32-2-1030. Definitions. As used in 32-2-1030 through 32-2-1034, unless the context requires otherwise, the following definitions apply:

(1) "Emergency" means any condition or occurrence that may interfere physically with the conduct of normal business operations at any of the offices of a mutual association or that poses an imminent or existing threat to the safety or security of persons or property or both. Situations that an emergency may arise as a result of include but are not limited to:

(a) fire;
(b) flood;
(c) earthquake;
(d) hurricanes;
(e) wind, rain, or snowstorms;
(f) labor disputes or strikes;
(g) power failures;
(h) transportation failures;
(i) interruption of communication facilities;
(j) shortages of fuel, housing, food, transportation, or labor;
(k) robbery or attempted robbery;
(l) actual or threatened enemy attack;
(m) epidemics or other catastrophes; or
(n) riots, civil commotions, and other acts of lawlessness or violence, actual or threatened.

(2) "Mutual association" includes state mutual associations, any person or association of persons lawfully carrying on the business of mutual associations, whether incorporated or not, and, to the extent that the provisions of 32-2-1031 through 32-2-1034 are not inconsistent with and do not infringe on paramount federal law, also includes federal savings associations.

(3) "Office" means any place at which a mutual association transacts its business or conducts operations related to its business.

(4) "Officer" means a person or persons designated by the board of directors, board of trustees, or other governing body of a mutual association to act for the mutual association in carrying out the provisions of 32-2-1031 through 32-2-1034 or, in the absence of a designation or of the officer or officers designated, the president or any other officer currently in charge of the mutual association or of the office or offices involved.

History: En. Sec. 112, Ch. 431, L. 2021.

32-2-1031. Power of department. When the department feels that an emergency exists or is impending in this state or in any part of this state, it may, by proclamation, authorize mutual associations located in the affected area to close any of their offices. In addition, if the department is of the opinion that an emergency exists or is impending that affects or may affect a particular mutual association or mutual associations, or a particular office or offices of a particular mutual association, but not mutual associations located in the area generally, it may authorize the particular mutual association or mutual associations or office or offices so affected to close. The closed office or offices must remain closed until the department proclaims that the emergency has ended or until an earlier time that the officers of the mutual association determine that one or more of the closed offices should reopen and, in either event, for the amount of time afterward as may reasonably be required for them to reopen.

History: En. Sec. 113, Ch. 431, L. 2021.

32-2-1032. Powers of officers. (1) When the officers of a mutual association feel that an emergency exists or is impending that affects or may affect any of a mutual association's offices, they may, in the reasonable and proper exercise of their discretion, determine not to open any of those offices on any business day or, if the offices have opened, to close any of those offices during the continuation of the emergency, even if the department has not issued and does not issue a proclamation of emergency. An office closed in this way shall remain closed until the officers determine that the emergency has ended and for a further time afterward as may reasonably be required for them to reopen. However, an office may not remain closed for more than 48 consecutive hours, excluding other legal holidays, without requesting the approval of the department.

(2) The officers of a mutual association may close any of the mutual association's offices on any day:

(a) designated by proclamation of the president of the United States or the governor of this state as a day of mourning, rejoicing, or other special observance; or

(b) that the federal reserve bank of Minneapolis is not open for business.

History: **En. Sec. 114, Ch. 431, L. 2021.**

32-2-1033. Notice of mutual association closing. A mutual association closing an office under authority granted under 32-2-1032 shall give to the department as prompt notice of its action as conditions will permit and by any means available. In the case of a federal savings association, the notice must be given to the comptroller of the currency.

History: **En. Sec. 115, Ch. 431, L. 2021.**

32-2-1034. Effect of closing. (1) A day on which a mutual association or any of its offices is closed during any part of its normal mutual association hours under 32-2-1031 and 32-2-1032 with respect to that mutual association or, if not all of its offices are closed, then with respect to the office or offices that are closed is a legal holiday for all purposes with respect to any mutual association business. No liability or loss of rights of any kind on the part of a mutual association, or a director, officer, or employee of the mutual association, may accrue or result by virtue of a closing authorized by 32-2-1031 and 32-2-1032.

(2) The provisions of 32-2-1030 through 32-2-1034 are in addition to any other law of this state or of the United States authorizing the closing of a mutual association or excusing the delay by a mutual association in the performance of its duties and obligations because of emergencies or conditions beyond the mutual association's control or otherwise.

History: **En. Sec. 116, Ch. 431, L. 2021.**

Part 11
Federal Deposit Insurance Corporation

32-2-1101. Definition of savings institution. As used in this part, the term "savings institution" means a mutual association that is organized under the laws of this state.

History: **En. Sec. 117, Ch. 431, L. 2021.**

32-2-1102. Savings institutions empowered to receive federal deposit insurance corporation aid. (1) A savings institution may, on the authority of its board of directors or a majority of the board, enter into the contracts, incur the obligations, and generally perform any acts necessary or appropriate in order to take advantage of any memberships, loans, subscriptions, contracts, grants, rights, or privileges available to savings institutions or to their depositors, creditors, conservators, or liquidators by virtue of the provisions of the Federal Deposit Insurance Act that establish the federal deposit insurance corporation and provide for the insurance of deposits or of any other act or resolution of congress to aid, regulate, or safeguard savings institutions and their depositors.

(2) A savings institution may subscribe for and acquire stock, debentures, bonds, or other types of securities of the federal deposit insurance corporation and may comply with the lawful rules and requirements from time to time adopted by that corporation.

History: **En. Sec. 118, Ch. 431, L. 2021.**

32-2-1103. Appointment of corporation as agent in liquidation. If a savings institution whose deposits are in any extent insured by the federal deposit insurance corporation created by the Federal Deposit Insurance Act, 12 U.S.C. 1811 through 1831, is closed on account of the savings institution's inability to meet the demands of its creditors, the department may appoint the corporation agent, without bond, to assist the department or act for it in the liquidation of that savings institution.

History: **En. Sec. 119, Ch. 431, L. 2021.**

32-2-1104. Subrogation of corporation. Whenever any savings institution has been closed as provided in 32-2-1103 and the federal deposit insurance corporation pays or makes available for payment the insured deposit liabilities of the closed savings institution, the federal deposit and insurance corporation, whether or not it has been appointed agent of the department in the liquidation of the closed savings institution, must be and become subrogated by operation of law to all rights against the closed savings institution of each owner of a claim for deposit to the extent necessary to enable the federal deposit insurance corporation, under federal law, to make insurance payments available to depositors of closed insured savings institutions.

History: **En. Sec. 120, Ch. 431, L. 2021.**

32-2-1105. Examinations by corporation. (1) The department may accept, in its discretion, in place of any examination authorized by the laws of this state to be conducted of a savings institution by the department, the examination made of the savings institution within a reasonable period by the federal deposit insurance corporation if a signed copy of the examination is furnished to the department.

(2) The department may also, in its discretion, accept a report relative to the condition of a savings institution obtained by the corporation within a reasonable period, in place of a report authorized by the laws of this state to be required of the savings institution by the department, if a copy of the report is furnished to the department.

(3) The department may, in its discretion, disclose to the corporation, or an official or examiner of the corporation, any information possessed by the department with reference to the conditions or affairs of an insured savings institution. The department may furnish to the corporation or to an official examiner of the corporation a copy or copies of any examinations made of those savings institutions and of any reports made by them.

History: **En. Sec. 121, Ch. 431, L. 2021.**

32-2-1106. Closed savings institutions empowered to borrow from corporation. (1) If a savings institution is closed on account of the savings institution's inability to meet the demands of its depositors, by action of the department, by action of its directors, or in the event of its insolvency or suspension, the department or the department's agent may borrow from the corporation and furnish any of the assets of the savings institution to the corporation as security for a loan from the corporation. The department may sell to the corporation any part or all of the assets of the savings institution.

(2) The provisions of this section do not limit the power of a savings institution or the department to pledge or sell assets in accordance with any existing law.

History: **En. Sec. 122, Ch. 431, L. 2021.**

Part 12
Removal of Directors or Officers

32-2-1201. Definitions. As used in this part, the following definitions apply:

(1) "Board member" means a member of the board of directors of the institution.

(2) "Cease and desist order that has become final" means a cease and desist order or an order with respect to which:

(a) a timely petition for review of the action has not been filed; or

(b) the action of the court in which a petition for review has been filed is not subject to further review by the courts of the state.

(3) "Institution" means a state mutual association.

(4) "Violation" includes without limitation any action, alone or with others, that causes, counsels, aids, or abets a violation.

History: **En. Sec. 123, Ch. 431, L. 2021.**

32-2-1202. Notice of charges — hearing — cease and desist order — effective date. (1) If the department has reasonable cause to believe that any institution is engaging, has engaged, or is about to engage in an unsafe or unsound practice in conducting the business of the institution or is violating, has violated, or is about to violate a law or rule, the department may issue and serve on the institution a notice of charges. The notice must contain a statement of the facts constituting the alleged unsafe or unsound practice or violation and must fix a time and place at which an administrative hearing pursuant to Title 2, chapter 4, part 6, will be held to determine whether an order to cease and desist should be issued against the institution.

(2) The hearing may not be earlier than 30 days or later than 60 days after service of the notice unless an earlier or a later date is set by the hearings examiner at the request of the institution. Unless the institution appears at the hearing by a duly authorized representative, it is considered to have consented to the issuance of the cease and desist order. In the event of

consent or if upon the record made at any such hearing the hearings examiner finds that any unsafe or unsound practice or violation specified in the notice of charges has been established by the preponderance of the evidence, the commissioner may issue and serve on the institution an order to cease and desist from the practice or violation. By provisions that may be mandatory or otherwise, the order may require the institution and its board members, officers, employees, and agents to cease and desist from the practice or violation and to take affirmative action to correct the conditions resulting from the practice or violation.

(3) A cease and desist order becomes effective at the expiration of 30 days after the service of the order on the institution, except in the case of an order issued on consent, which is effective at the time specified. The cease and desist order remains effective and enforceable, except to the extent it is stayed, modified, terminated, or set aside by the action of the commissioner or a reviewing court.

History: **En. Sec. 124, Ch. 431, L. 2021.**

32-2-1203. Informal conferences — time for application. Within 15 days after service of the notice of charges, either the institution or the department may request an informal conference to discuss the charges and the possible disposition of the charges without a formal hearing process. The conference must be carried out in accordance with the provisions of 2-4-603. Upon a proper showing, the department may withdraw charges and proceedings for a cease and desist order.

History: **En. Sec. 125, Ch. 431, L. 2021.**

32-2-1204. Temporary cease and desist order — grounds for issuance — effective date — injunctive relief. (1) (a) Whenever the department determines that any violation or threatened violation or any unsafe or unsound practice specified in the notice of charges served on the institution pursuant to 32-2-1202(1) or the continuation is likely to cause insolvency or substantial dissipation of assets or earnings of the institution or is likely to otherwise seriously prejudice the interests of its depositors, the department may issue a temporary order requiring the institution to cease and desist from the violation or practice.

(b) The order must contain a statement of the facts constituting the alleged violation or unsafe or unsound practice.

(c) The order is effective upon service of the order on the institution and, unless set aside, limited, or suspended by a court in proceedings authorized by subsection (2), remains effective and enforceable until the completion of the administrative proceedings pursuant to the notice of charges, until the department dismisses the charges specified in the notice, or until a cease and desist order that is issued against the institution after the hearing becomes effective.

(2) Within 14 days after the institution has been served with a temporary cease and desist order, the institution may apply to the district court for the county in which the home office of the institution is located for an injunction setting aside, limiting, or suspending the enforcement, operation, or effectiveness of the order pending the completion of the administrative proceedings held pursuant to the notice of charges served on the institution under 32-2-1202(1). The court has jurisdiction to issue the injunction.

History: **En. Sec. 126, Ch. 431, L. 2021.**

32-2-1205. Notice of intention to remove board member or officer — prohibiting participation — suspension. (1) The department may serve on a board member or officer of an institution a written notice of intention to remove the member or officer from office whenever the department has reasonable cause to believe that:

(a) the board member or officer has:

(i) committed any violation of law involving dishonesty or breach of trust;

(ii) violated a cease and desist order that has become final;

(iii) engaged or participated in any unsafe or unsound practice in connection with the institution; or

(iv) committed or engaged in any act, omission, or practice that constitutes a breach of the member's or officer's fiduciary duty as a board member or officer of the institution; and

(b) the institution has suffered or will likely suffer substantial financial loss or other damage or the interest of its depositors could be seriously prejudiced by reason of the violation, practice, or breach of fiduciary duty involving personal dishonesty on the part of the board member or officer.

(2) The department may serve on a board member, officer, or other person of an institution a written notice of intention to remove the individual from office or to prohibit the individual's further participation in any manner in the conduct of the affairs of the institution if:

(a) in the opinion of the department, the board member or officer has, by conduct or practice with respect to another institution or business organization that has resulted in substantial financial loss or other damage to that institution or business organization, evidenced the member's or officer's personal disability and unfitness to continue as a board member or officer of the institution; or

(b) the department has reasonable cause to believe that any other person participating in the conduct of the affairs of the institution has, by conduct or practice with respect to the institution, another institution, or other business organization that has resulted in substantial financial loss or other damage to the institution or business organization, evidenced the person's personal disability and unfitness to participate in the conduct of the affairs of the institution.

(3) A notice of intention to remove a board member, officer, or other person from office or to prohibit the individual's participation in the conduct of the affairs of an institution must contain a statement of the facts constituting grounds for the removal or prohibition and must fix a time and place at which a hearing will be held on the removal or prohibition. The hearing must be held not earlier than 30 days or later than 60 days after the date of service of the notice, unless an earlier or later date is set by the hearings examiner at the request of the individual and for good cause shown.

(4) Unless the board member, officer, or other person appears at the hearing in person or by a duly authorized representative, the individual must be considered to have consented to the issuance of an order of removal or prohibition. In the event of consent or if on the record made at the hearing the hearings examiner finds that any of the grounds specified in the notice have been established by a preponderance of the evidence, the commissioner may issue orders of suspension, removal from office, or prohibition from participation in the conduct of the affairs of the institution, as the commissioner considers appropriate. The order becomes effective 30 days after service on the institution and the individual concerned, except in the case of an order issued on consent, which becomes effective at the time specified in the order. The order remains effective and enforceable until it is stayed, modified, terminated, or set aside by action of a reviewing court.

History: **En. Sec. 127, Ch. 431, L. 2021.**

32-2-1206. Informal conferences — time for application. Within 15 days after service of the notice of charges sent pursuant to 32-2-1205, the board member, officer, or other person may request an informal conference to discuss the charges and the possible disposition of the charges without a formal hearing process. The conference must be carried out in accordance with 2-4-603. Upon a proper showing, the department may withdraw charges and proceedings for a cease and desist order.

History: **En. Sec. 128, Ch. 431, L. 2021.**

32-2-1207. Suspension or prohibition effective on service — stay. (1) (a) With respect to any board member, officer, or other person of an institution to whom notice is sent pursuant to 32-2-1205, if the department considers it necessary for the protection of the institution or the interests of its depositors that the individual be suspended from office or prohibited from further participation in any manner in the conduct of the affairs of the institution, the department may serve on the individual a written notice suspending the individual from office or prohibiting the individual from further participation in any manner in the conduct of the affairs of the institution.

(b) The notice must contain a statement of the facts constituting grounds for the order and must fix a time, not later than 14 days from the date of the service of the notice, at which a hearing will be held to afford the individual the opportunity to respond.

(c) The suspension or prohibition is effective on service of the notice, and unless stayed by a court in proceedings authorized by subsection (2), remains in effect until:

(i) the completion of the administrative proceedings pursuant to the notice served under 32-2-1204;

(ii) the department dismisses the charges specified in the notice; or

(iii) the order of removal or prohibition that is issued against the board member, officer, or other person becomes effective.

(d) Copies of the notice must also be served on the institution of which the individual is a director or officer or in the conduct of whose affairs the individual has participated.

(2) Within 14 days after the hearing provided for in subsection (1), the board member, officer, or other person may apply to the district court for the county in which the home office of the institution is located for a stay of the suspension or prohibition pending the completion of the administrative proceedings pursuant to the notice served on the individual under 32-2-1204. The court has jurisdiction to stay the suspension or prohibition.

History: En. Sec. 129, Ch. 431, L. 2021.

32-2-1208. Felony charges — suspension or prohibition. (1) (a) If a board member, officer, or other person participating in the conduct of the affairs of an institution is charged in any information, indictment, warrant, or complaint authorized by a county, state, or federal authority with the commission of or participation in a felony involving dishonesty or breach of trust, the department by written notice served on the individual may suspend that individual from office or prohibit that individual from further participation in any manner in the conduct of the affairs of the institution. Suspension is effective upon service on the individual.

(b) The notice must contain a statement of the facts constituting grounds for the order and must fix a place and time, not later than 14 days from the date of the notice, at which a hearing will be held to afford the individual the opportunity to respond. A copy of the notice must also be served on the institution.

(c) The suspension or prohibition remains in effect until the information, indictment, warrant, or complaint is finally disposed of or until terminated by the commissioner.

(2) Within 14 days after the hearing provided for in subsection (1), the board member, officer, or other person may apply to the district court for the county in which the home office of the institution is located for a stay of the suspension or prohibition pending the completion of the criminal proceedings initiated by the information, indictment, warrant, or complaint. The court has jurisdiction to stay the suspension or prohibition.

(3) (a) If a judgment of conviction with respect to the offense is entered against the board member, officer, or other person and at the time that the judgment is not subject to further appellate review, the department may issue and serve on the individual an order removing that individual from office or prohibiting that individual from further participation in any manner in the conduct of the affairs of the institution except with the consent of the commissioner. A copy of the order must also be served on the institution, and upon receipt the board member or officer, if applicable, ceases to be a board member or officer of the institution.

(b) A finding of not guilty or other disposition of the charge does not preclude the department from instituting proceedings to suspend or remove the individual from office or to prohibit further participation in the affairs of the institution pursuant to 32-2-1205 and 32-2-1206.

History: En. Sec. 130, Ch. 431, L. 2021.

32-2-1209 through 32-2-1212 reserved.

32-2-1213. Board of directors — lack of quorum — temporary board members. (1) If at any time because of the suspension or removal of one or more board members pursuant to this part the board of directors of an institution has less than a quorum of board members not suspended or removed, all powers and functions vested in or exercisable by the board vest in and are exercisable by the board members not suspended or removed until a time when there is a quorum of the board members.

(2) If all of the board members have been suspended or removed, the commissioner shall appoint persons to serve temporarily as board members, pending the termination of the suspensions or removals or until a time when their successors are duly elected and take office.

History: En. Sec. 131, Ch. 431, L. 2021.

32-2-1214. Hearings — decision — review, modification, termination, or stay of orders. (1) A hearing provided for in this part must be conducted in accordance with the provisions of the Montana Administrative Procedure Act. The hearing must be private unless the commissioner, after fully considering the views of the party afforded the hearing, determines that a public hearing is necessary to protect the public interest. Within 90 days after the case has been submitted for final decision, the hearings examiner shall render a decision, which must include findings of fact on which the decision is based. The commissioner shall comply with 2-4-623 and issue and serve on each party to the proceeding an order consistent with the provisions of this section.

(2) (a) Any party to the hearing or any person required by an order issued under this part to cease and desist from any of the violations or practices stated in the order or any person suspended, removed, or prohibited from participation in the conduct of the affairs of an institution may obtain a review of any order, other than a consent order. The review must be pursuant to the Montana Administrative Procedure Act.

(b) Unless a petition for review is timely filed as provided in the Montana Administrative Procedure Act, the commissioner, at any time, on notice and in a manner that the commissioner considers proper, may modify, terminate, or set aside the order. Upon the timely filing of a petition for review, the commissioner may modify, terminate, or set aside the order with the permission of the court.

History: **En. Sec. 132, Ch. 431, L. 2021.**

32-2-1215. Notices and orders — manner of service — copies to federal authorities. Any service required or authorized to be made by the department pursuant to this part must be made on individual board members and officers by personal service and may be made on institutions by registered or certified mail or common courier with tracking capability or in any manner reasonably calculated to give actual notice as the department by rule or otherwise may provide. Copies of any notice or order served by the commissioner pursuant to the provisions of this part on any institution or any board member, officer, or other person participating in the conduct of the institution's affairs may also be sent to the appropriate federal supervisory authorities.

History: **En. Sec. 133, Ch. 431, L. 2021.**

32-2-1216. Enforcement of notices or orders. The commissioner may apply to the district court of the county in which the home office of the institution is located or to the district court for Lewis and Clark County for the enforcement of any effective and outstanding notice or order issued under this part. The court has jurisdiction to require compliance.

History: **En. Sec. 134, Ch. 431, L. 2021.**

32-2-1217. Violation of notice or final order — penalties. Any present or former board member or officer of an institution or any other person against whom an outstanding and effective notice or final order has been served pursuant to 32-2-1205, 32-2-1207, or 32-2-1208 is subject to the penalties in 32-2-607(5) if the individual:

(1) participates in any manner in the conduct of the affairs of the institution;

(2) directly or indirectly solicits, procures, transfers, or attempts to transfer votes or attempts to vote any proxies, consents, or authorizations in respect to any voting rights in the institution; or

(3) without the prior written approval of the commissioner, votes for a board member or serves as a board member, officer, or employee of the institution.

History: **En. Sec. 135, Ch. 431, L. 2021.**

CHAPTER 3
CREDIT UNIONS

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Chapter Cross-References

Credit Transactions and Relationships, Title 31.
Insurance premium finance companies, Title 33, ch. 14.
Discrimination prohibited in financial transactions, 49-2-305, 49-2-307, 49-3-206.
Montana Uniform Transfers to Minors Act, Title 72, ch. 26.

Part 1
General Provisions

32-3-101. Short title. This chapter shall be known and may be cited as the "Montana Credit Union Act".

History: En. 14-601 by Sec. 1, Ch. 38, L. 1975; R.C.M. 1947, 14-601.

32-3-102. Purposes — definitions. (1) The purposes of a credit union are to:

(a) encourage thrift among its members;

(b) create a source of credit at a fair and reasonable rate of interest; and

(c) provide an opportunity for the credit union's members to use and control their own money in order to improve their economic and social condition.

(2) For the purposes of this chapter, unless the context requires otherwise, the following definitions apply:

(a) "Credit union" means a cooperative, nonprofit association incorporated under the laws of this state pursuant to this chapter for the purposes described in subsection (1).

(b) "Immediate family" means a spouse, a child, a sibling, a parent, a grandparent, or a grandchild and includes stepparents, stepchildren, stepsiblings, and adoptive relationships.

(c) "Membership shares" means a fee paid to the credit union to be a member. The fee is held by the credit union and may be invested by the credit union. The fee must be set in the bylaws of the credit union.

(d) "Official" means a member of the board of directors, supervisory committee, or credit committee of the credit union and includes individuals elected by the board of directors to serve as executive officers described in 32-3-408.

(e) "Shares" means a balance of funds, minus membership shares, held by a credit union and established in accordance with standards specified by the credit union. The term includes general references to shares as well as share accounts, share certificates, share draft accounts, custodial accounts, individual retirement accounts, payable on death accounts, trust accounts, money market accounts, share checking accounts, and business share accounts.

History: En. 14-602 by Sec. 2, Ch. 38, L. 1975; R.C.M. 1947, 14-602; amd. Sec. 1, Ch. 317, L. 2015.

Cross-References

Commercial bank defined, 32-1-105.
Savings bank defined, 32-1-106.
Trust company defined — purposes for which may be formed, 32-1-107.
Investment company defined — purposes for which may be formed, 32-1-108.
Mutual savings and loan associations — short title — application — purpose, 32-2-601.

32-3-103. Use of name exclusive. (1) The name of any credit union organized under this chapter must include the phrase "credit union". A credit union may not adopt a name either identical to the name of any other credit union doing business in this state or so similar as to be misleading or to cause confusion.

(2) A person, other than a credit union organized under the provisions of this chapter or of any other credit union act or an organization or corporation whose membership or ownership is primarily limited to credit unions or credit union organizations, may not use a name or title containing the words "credit union" or any derivation of the words "credit union", and the person may not represent that the person is a credit union and may not conduct business as a credit union.

(3) A person who violates a provision of this section shall be fined not more than $500 or imprisoned not more than 1 year, or both, and may be permanently enjoined from further violation of the provisions of this section.

History: En. 14-606 by Sec. 6, Ch. 38, L. 1975; R.C.M. 1947, 14-606; amd. Sec. 1, Ch. 237, L. 2003.

Cross-References

Registration of assumed business name similar to reserved or registered name or mark prohibited, 30-13-202.
Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.

32-3-104. Office facilities. (1) A credit union may change its place of business within this state upon written notice to the department of administration.

(2) A credit union may share office space with one or more credit unions and contract with any person or corporation to provide facilities or personnel.

(3) A credit union may maintain, upon prior written notice to the department, additional offices at locations other than its principal place of business if the purpose of maintaining the additional offices is to furnish service to its members.

(4) The department shall approve any additional office unless a compelling reason for disapproval is found by the department. Competition with other financial institutions is not a sufficiently compelling reason for disapproval.

(5) If the department disapproves an additional office, the credit union must be afforded an opportunity for a hearing according to Title 2, chapter 4, part 6. The purpose of the hearing is to determine whether a compelling reason exists for disapproval of the additional office.

History: En. 14-607 by Sec. 7, Ch. 38, L. 1975; R.C.M. 1947, 14-607; amd. Sec. 1, Ch. 140, L. 1981; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 83, Ch. 483, L. 2001.

Cross-References

Branch bank — detached facilities, 32-1-372.

32-3-105. Fiscal year. The fiscal year of each credit union organized under this chapter shall end on December 31.

History: En. 14-608 by Sec. 8, Ch. 38, L. 1975; R.C.M. 1947, 14-608.

32-3-106. Establishment of a student financial institution. Credit unions may establish a school financial institution, as defined in 32-1-115 and in accordance with 32-1-115.

History: En. 14-675 by Sec. 75, Ch. 38, L. 1975; R.C.M. 1947, 14-675; amd. Sec. 5, Ch. 340, L. 2003; amd. Sec. 28, Ch. 75, L. 2019.

Cross-References

Superintendent of Public Instruction — supervision of schools — powers and duties, 20-3-106.

Instructional assistance by Superintendent of Public Instruction, 20-7-114.

Part 2
Regulation

Part Cross-References

Special examination of credit unions by Department, 32-1-215.

32-3-201. Department of administration. (1) The department of administration shall administer the laws of this state relating to credit unions. The department may appoint or employ special assistants, deputies, examiners, or other employees that are necessary for the purpose of administering or enforcing this chapter.

(2) The department may adopt rules for the administration of this chapter and may establish chartering, supervisory, and examination fees. Fees collected must be deposited in the state special revenue fund for the use of the department in its supervision function.

(3) The department shall adopt rules prescribing the minimum amount of surety bond coverage and casualty, liability, and fire insurance required of credit unions in relation to their assets or to the money and other personal property involved or their exposure to risk.

(4) The department may enter into agreements with other states establishing the division of supervisory responsibilities between the state in which a credit union is organized and the state or states in which the credit union's branches may be located.

History: En. 14-609 by Sec. 9, Ch. 38, L. 1975; R.C.M. 1947, 14-609; amd. Sec. 5, Ch. 600, L. 1985; amd. Sec. 84, Ch. 483, L. 2001; amd. Sec. 4, Ch. 237, L. 2003.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

State finance — fund structure, 17-2-102.

Suretyship, Title 28, ch. 11, part 4.

Casualty insurance, Title 33, ch. 23.

32-3-202. Reports. (1) Credit unions organized under this chapter shall report to the department of administration annually on or before February 1 on forms supplied by the department for that purpose. Additional reports may be required.

(2) A fine of $5 for each day a report is in arrears must be levied against the offending credit union unless it is excused for cause by the department.

History: En. 14-610 by Sec. 10, Ch. 38, L. 1975; R.C.M. 1947, 14-610; amd. Sec. 5, Ch. 237, L. 2003.

Cross-References

Duties of supervisory committee or board, 32-3-417.

32-3-203. Examinations. (1) The department of administration shall examine or cause to be examined each credit union on a schedule determined by the department. Each credit union and all of its officers and agents shall give representatives of the department full access to all books, papers, securities, records, and other sources of information under their control. For the purpose of the examination, the representatives may subpoena witnesses, administer oaths, compel the giving of testimony, and require the submission of documents.

(2) A report of the examination must be forwarded to the executive officer of each credit union promptly after completion. The report must contain comments relative to the management of the affairs of the credit union and also as to the general condition of its assets. Within 60 days after the receipt of the report, the directors and committee members shall meet to consider matters contained in the report.

(3) In lieu of making an examination of a credit union, the department may accept an audit report of the condition of the credit union made by an auditor approved by the department. The cost of the audit must be borne by the credit union.

History: En. 14-611 by Sec. 11, Ch. 38, L. 1975; R.C.M. 1947, 14-611; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 85, Ch. 483, L. 2001; amd. Sec. 1, Ch. 64, L. 2003; amd. Sec. 6, Ch. 237, L. 2003.

Cross-References

Banks and trust companies — examination and supervision by Department, 32-1-211.

Mutual savings and loan associations — examination and supervision by Department, 32-2-701.

32-3-204. Records. (1) A credit union shall maintain all books, records, accounting systems, and procedures in accordance with rules that the department of administration prescribes. In prescribing rules, the department shall consider the relative size of a credit union and its reasonable capability of compliance.

(2) A credit union is not liable for destroying records after the expiration of the record retention time prescribed by the department.

(3) A photostatic or photographic copy or reproduction of any kind, including electronic or computer-generated data that has been electronically stored and is capable of being converted into written form, of any credit union records is admissible as evidence of transactions with the credit union.

History: En. 14-612 by Sec. 12, Ch. 38, L. 1975; R.C.M. 1947, 14-612; amd. Sec. 1, Ch. 25, L. 2001; amd. Sec. 221(1), Ch. 483, L. 2001; amd. Sec. 7, Ch. 237, L. 2003.

Cross-References

Destruction of bank records, 32-1-491.

Reproduction of bank records — admissibility in evidence, 32-1-492.

32-3-205. Cease and desist orders — suspension — involuntary liquidation. (1) The department of administration may issue cease and desist orders after having determined, from competent and substantial evidence, that a credit union:

(a) is engaged or is about to engage in an unsafe or unsound practice; or

(b) is violating or has violated a material provision of any law, rule, or condition imposed in writing by the department or any written agreement made with the department.

(2) (a) The department may suspend from office and prohibit from further participation in any manner in the conduct of the affairs of a credit union any director, officer, or committee member who has committed any violation of a law, rule, or cease and desist order, who has engaged in or participated in any unsafe or unsound practice in connection with the credit union, or who has committed or engaged in any act, omission, or practice that constitutes a breach of that person's fiduciary duty as a director, officer, or committee member when the department has determined that:

(i) the action of the director, officer, or committee member has resulted or will likely result in substantial financial loss or other damage;

(ii) the interests of the credit union's members have been or may be prejudiced by the action of the director, officer, or committee member;

(iii) the director, officer, or committee member has received financial gain or other benefit as a result of the action; or

(iv) the action of the director, officer, or committee member involves personal dishonesty or demonstrates unfitness to serve as a director, officer, or committee member.

(b) A director, officer, or committee member suspended from office pursuant to subsection (2)(a) may request a hearing under the Montana Administrative Procedure Act.

(3) (a) If it appears that a credit union is bankrupt or insolvent or that it has willfully violated this chapter or is operating in an unsafe or unsound manner, the department may issue an order temporarily suspending the credit union's operations for not less than 30 or more than 60 days. The board of directors must be given notice by certified mail of the suspension. The notice must include a list of the reasons for the suspension and a list of the specific violations of this chapter.

(b) Upon receipt of a suspension notice, the credit union shall cease all operations, except those authorized by the department, or the department may appoint a conservator to operate the credit union during the period of suspension. The board of directors shall file with the department a reply to the suspension notice and present a plan of proposed corrective actions if it desires to continue operations. The board may request that the credit union be declared insolvent and a liquidating agent be appointed.

(c) Upon receipt from the suspended credit union of evidence that the conditions causing the order of suspension have been corrected or upon acceptance of a plan of proposed corrective actions, the department may revoke the suspension notice and permit the credit union to resume normal operations.

(d) If the department, after issuing a notice of suspension, rejects the credit union's plan to continue operations, the board may request an administrative hearing.

(4) If, within the suspension period, the credit union fails to answer the suspension notice or request a hearing or if after a hearing, the department continues to reject the credit union's plan to continue operations, the department may:

(a) permit the credit union to operate under a conservator until conditions requiring suspension are remedied;

(b) involuntarily merge the credit union in accordance with the provisions of 32-3-212; or

(c) revoke the credit union's charter, appoint a liquidating agent, and liquidate the credit union.

(5) The department may not involuntarily merge or involuntarily liquidate a credit union prior to the suspension procedures outlined in this section. A credit union may petition the appropriate court to stay the department's suspension, involuntary merger, or involuntary liquidation order.

(6) In the event of liquidation of a credit union, the assets of the credit union or the proceeds from the disposition of the credit union's assets must be applied and distributed in the following sequence:

(a) to secured creditors up to the value of their secured collateral;

(b) for the costs and expenses of liquidation;

(c) for wages due employees of the credit union;

(d) for taxes owed to any government unit;

(e) for any debts owed the United States;

(f) to general creditors and to secured creditors to the extent that their claims exceed the value of their collateral; and

(g) to shareholders of the credit union to the extent of their uninsured shares.

History: En. 14-664 by Sec. 64, Ch. 38, L. 1975; R.C.M. 1947, 14-664; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 86, Ch. 483, L. 2001; amd. Sec. 8, Ch. 237, L. 2003.

Cross-References

Injunctions, Title 27, ch. 19.
Dissolution, closing, and liquidation of banks, Title 32, ch. 1, part 5.
Share insurance, 32-3-611.

32-3-206. Authorized activities of credit unions. Upon written application to the department of administration, a credit union may engage in any activity in which a credit union could engage if it were operating as a federal chartered credit union at the time the authority is granted. The activities include but are not limited to the power to do any act and to own, possess, and carry as assets property including stocks, bonds, or other debentures that, at the time the authority is granted, are authorized under federal laws and regulations for transactions by federal credit unions and are not subject to any restrictions contained elsewhere in Montana law. However, the department may not charter a credit union not having a common bond of membership as defined in 32-3-304. The department shall approve an activity if it finds that the activity fosters competitive equality between state and federal credit unions and prevents adverse effects on members of state-chartered credit unions. If the department disapproves an activity, the credit union must be given an opportunity for a hearing pursuant to Title 2, chapter 4, part 6, to determine whether a compelling reason exists for denying approval of the activity for which the credit union applied.

History: En. 14-676 by Sec. 76, Ch. 38, L. 1975; R.C.M. 1947, 14-676; amd. Sec. 1, Ch. 522, L. 1985; amd. Sec. 12, Ch. 237, L. 2003.

Cross-References

Authorized activities of commercial bank, 32-1-105.
Authorized activities of savings bank, 32-1-106.
Authorized activities of trust company, 32-1-107.
Authorized activities of investment company, 32-1-108.
National bank powers extended to state banks, 32-1-362.
Conversion of charter, 32-3-323.

32-3-207. Confidentiality — penalties. (1) (a) Any report of examination issued under 32-3-203, any report made by a credit union under 32-3-202, and any other credit union documentation maintained by the department of administration, other than those reports that are required to be published, must be considered confidential information. Except as provided in subsection (1)(b), confidential information may not be imparted to persons who are not officially associated with the department, and the information contained in the reports and statements may be used by the department only in the furtherance of its official duties.

(b) The department may exchange information with federal credit union regulatory agencies, with a federal reserve bank, and with the financial regulatory departments of other states. The department may furnish reports of its examination findings under 32-3-203 to a federal home loan bank, as defined in the Federal Home Loan Bank Act of 1932, 12 U.S.C. 1422. The department may furnish information to the legislative auditor for use in pursuit of official duties. A prosecuting official may obtain the information by court order.

(2) Any knowledge or information gained or discovered by the department in pursuance of its powers or duties is confidential information of the department. The information may not, except as provided in subsection (1)(b), be imparted to any person not officially associated with the department. The information may be used by the department only in the furtherance of its official duties.

(3) An employee or agent of the department who violates this section or willfully makes a false official report as to the condition of a credit union is guilty of a felony and must be removed from office. Upon conviction, the person shall be fined an amount not exceeding $1,000, be imprisoned in a state correctional facility for a term not exceeding 5 years, or both.

History: En. Sec. 11, Ch. 237, L. 2003; amd. Sec. 2, Ch. 68, L. 2019.

32-3-208 through 32-3-210 reserved.

32-3-211. Conservatorship. (1) In conjunction with a suspension order or if the department of administration's examination has been obstructed or impeded, the department may appoint itself or appoint any other competent person as conservator to immediately take possession and control of the business and assets of a credit union. The conservator, representing the best interest of the credit union members, must be vested with the full power of management of the credit union.

(2) Not later than 15 days after the date on which the conservator takes possession and control of the business and assets of a credit union pursuant to subsection (1), the credit union may apply to the appropriate court for an order requiring the department to show cause why the department or the designated conservator should not be enjoined from continuing possession and control.

(3) Except as provided in subsection (2), the conservator may maintain possession and control of the business and assets of the credit union and may operate the credit union until:

(a) the department permits the credit union's officials to continue business subject to any terms and conditions the department imposes; or

(b) the credit union is involuntarily merged or involuntarily liquidated in accordance with the provisions of 32-3-205.

(4) The department may appoint any agents considered necessary to assist the conservator in carrying out the duties of the conservator under this section.

(5) All expenses incurred by the conservator in exercising the authority of that office under this section with respect to a credit union must be paid out of the assets of the credit union, except that the department may waive all or a part of the expenses.

History: En. Sec. 9, Ch. 237, L. 2003.

32-3-212. Involuntary merger. The department of administration may initiate the involuntary merger of a credit union that is insolvent or in danger of insolvency with any other credit union or may authorize a credit union to purchase any of the assets of or assume any of the liabilities of any other credit union that is insolvent or in danger of insolvency if the department is satisfied that:

(1) an emergency requiring expeditious action exists with respect to a credit union that is insolvent or in danger of insolvency;

(2) other alternatives are not reasonably available; and

(3) the public interest would best be served by approval of the merger, purchase, or assumption.

History: En. Sec. 10, Ch. 237, L. 2003.

32-3-213 and 32-3-214 reserved.

32-3-215. Out-of-state credit unions. (1) A credit union chartered under the laws of another state or territory of the United States may conduct business as a credit union in this state with the approval of the department of administration, provided that credit unions incorporated under this chapter are allowed to do business in the other state or territory under conditions similar to these provisions.

(2) Before granting approval to do business in this state, the department must find that an out-of-state credit union:

(a) is a credit union organized under laws similar to this chapter;

(b) is financially solvent;

(c) has account insurance comparable to that required for credit unions incorporated under this chapter;

(d) is examined and supervised by a regulatory agency of the state in which it is organized; and

(e) needs to conduct business in this state to adequately serve its members in this state.

(3) An out-of-state credit union may not conduct business in this state unless it:

(a) complies with the consumer protection statutes and rules applicable to credit unions incorporated under this chapter;

(b) agrees to furnish the department with a copy of the examination report conducted by its regulatory agency or to submit to an examination by the department; and

(c) designates and maintains an agent for the service of process in this state.

(4) The department may revoke the approval of an out-of-state credit union conducting business in this state if the department finds that:

(a) the credit union no longer meets the requirements of subsection (2);

(b) the credit union has violated the laws of this state or lawful rules or orders issued by the department;

(c) the credit union has engaged in a pattern of unsafe or unsound credit union practices;

(d) continued operation by the credit union is likely to have a substantially adverse impact on the financial, economic, or other interests of residents of this state; or

(e) the credit union is prohibited from operating in its own home state.

History: En. Sec. 2, Ch. 237, L. 2003.

32-3-216. Conducting business outside this state. (1) A credit union chartered under this chapter may conduct business outside of this state in other states or territories where it is permitted to conduct business as a credit union, under conditions substantially similar to the provisions of this chapter.

(2) If another state or territory's credit union laws or regulations allow credit unions operating in that state or territory to exercise additional powers not allowed in this state, the credit union conducting business outside this state may request permission from the department of administration to exercise those additional powers while operating in that state.

(3) Upon request for approval to exercise a power not allowed in this state, submitted by certified mail, return receipt requested, the department shall respond with a determination in not more than 60 days. For good cause shown within the 60-day period, the department may extend the response period for an additional 30 days. If a response is not received within 60 days or 90 days, as applicable, the requesting credit union may exercise the power.

History: En. Sec. 3, Ch. 237, L. 2003.

Part 3
Organization, Membership, and Dissolution

32-3-301. Organization procedure. (1) Any seven or more residents of this state who are of legal age and who have a common bond, as described in 32-3-304, may organize a credit union and become charter members of the credit union by complying with this section.

(2) The subscribers shall execute articles of incorporation that conform to the applicable Montana corporation law and shall agree to the terms of the articles. The articles must state:

(a) the name, which must include the words "credit union" and which must conform with the provisions of 32-3-103, and the location where the proposed credit union is to have its principal place of business;

(b) that the existence of the credit union is perpetual;

(c) the par value of the shares of the credit union, which must be in $5 multiples of not less than $5 or more than $50;

(d) that the credit union is organized under this chapter for the purposes set forth in the articles;

(e) the names and addresses of the subscribers to the articles of incorporation and the value of shares subscribed to by each, which may be not less than $5; and

(f) that the credit union may exercise incidental powers that are necessary or requisite to enable it to carry on effectively the business for which it is incorporated and those powers that are inherent in the credit union as a legal entity.

(3) The subscribers shall prepare and adopt bylaws for the general government of the credit union, consistent with this chapter, and forward the bylaws as provided in subsection (5).

(4) The subscribers shall select at least five qualified persons who agree to serve on the board of directors and at least three qualified persons who agree to serve on the supervisory committee. A signed agreement to serve in these capacities until the first annual meeting or until the election of their successors, whichever is later, must be executed by the parties. This agreement must be submitted to the department of administration.

(5) (a) The subscribers shall forward the articles of incorporation and the bylaws to the department. The department may issue a certificate of approval if the articles and the bylaws are in conformity with this chapter and if the department is satisfied that the proposed operation is favorable to the success of the credit union and that the standing of the proposed organizers gives assurance that the credit union's affairs will be properly administered. The department shall return to the applicants or their representatives an approved copy of the bylaws and the articles, which must be preserved in the permanent files of the credit union, or provide a written reason if the application is denied.

(b) The articles of incorporation must be filed with the secretary of state who, upon payment of the fees for filing the articles, shall issue a certificate of incorporation.

(6) The subscribers for a credit union charter may not transact any business until formal approval of the charter has been received.

(7) If the department denies a certificate of approval, the subscribers may request a hearing under the Montana Administrative Procedure Act, Title 2, chapter 4.

History: En. 14-603 by Sec. 3, Ch. 38, L. 1975; R.C.M. 1947, 14-603; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 2, Ch. 25, L. 2001; amd. Sec. 87, Ch. 483, L. 2001; amd. Sec. 13, Ch. 237, L. 2003; amd. Sec. 2, Ch. 317, L. 2015.

Cross-References

Adult rights, Art. II, sec. 14, Mont. Const.

Formation of banks and trust companies, Title 32, ch. 1, part 3.

Election or appointment of officials, 32-3-403.

32-3-302. Form of articles and bylaws. In order to simplify the organization of credit unions, the department of administration shall prepare a form of articles of incorporation and a form of bylaws, consistent with this chapter, that may be used by credit union incorporators for their guidance. The articles of incorporation and bylaws must be available without charge to persons desiring to organize a credit union.

History: En. 14-604 by Sec. 4, Ch. 38, L. 1975; R.C.M. 1947, 14-604; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 88, Ch. 483, L. 2001; amd. Sec. 14, Ch. 237, L. 2003.

Cross-References

Banks and trust companies — bylaws, 32-1-308.

Mutual savings and loan associations — bylaws, 32-2-807.

32-3-303. Amendments. (1) The articles of incorporation or the bylaws may be amended as provided in the bylaws. Amendments to the articles of incorporation or bylaws must be submitted, by certified mail, return receipt requested, to the department of administration, which shall approve or disapprove the amendments within 60 days.

(2) Amendments become effective upon:

(a) approval in writing by the department, for which a fee may not be charged; and

(b) in the case of articles of incorporation, filing with the secretary of state.

(3) If the department does not approve or disapprove the amendments within the 60-day period, the amendments must be considered approved, except that the department may extend

the approval period for an additional 30 days for good cause as stated in a written notice given to the credit union within the original 60-day period.

History: En. 14-605 by Sec. 5, Ch. 38, L. 1975; amd. Sec. 32, Ch. 71, L. 1977; R.C.M. 1947, 14-605; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 89, Ch. 483, L. 2001; amd. Sec. 15, Ch. 237, L. 2003.

32-3-304. Membership defined. (1) The membership of a credit union shall be limited to and consist of the subscribers to the articles of incorporation and such other persons within the common bond set forth in the bylaws as have been duly admitted members, have paid the required entrance fee or membership fee, or both, have subscribed for one or more shares and have paid the initial installment thereon, and have complied with such other requirements as the articles of incorporation or bylaws specify.

(2) Credit union membership may include groups having a common bond of similar occupation, association, or interests or groups within a well-defined neighborhood, community, or rural district or employees of a common employer and members of the immediate family of such persons.

History: En. 14-615 by Sec. 15, Ch. 38, L. 1975; R.C.M. 1947, 14-615; amd. Sec. 1, Ch. 107, L. 1981.

Cross-References

Authorized activities of credit unions, 32-3-206.

32-3-305. Societies — associations. (1) Societies and partnerships composed primarily of individuals who are eligible for membership and corporations whose stockholders are composed primarily of such individuals may be admitted to membership in the same manner and under the same conditions as individuals.

(2) No loan may be made to any member society, partnership, or corporation in an aggregate amount that is in excess of 5% of the credit union's shares and retained earnings. Total loans to member societies, partnerships, and corporations is limited to an aggregate amount of 15% of the credit union's shares and retained earnings.

History: En. 14-616 by Sec. 16, Ch. 38, L. 1975; R.C.M. 1947, 14-616; amd. Sec. 2, Ch. 522, L. 1985.

Cross-References

Limitations on loans — banks and trust companies, 32-1-432.

Loans to managing officer or director — banks, 32-1-467.

32-3-306. Other credit unions. Any credit union organized under this chapter may permit membership of any other credit union organized under this chapter or other laws.

History: En. 14-617 by Sec. 17, Ch. 38, L. 1975; R.C.M. 1947, 14-617.

Cross-References

Corporate credit unions, Title 32, ch. 3, part 8.

32-3-307. Limited-income persons. Existing credit unions may include within their field of membership limited-income persons, as defined by the department of administration, for whom credit union services are otherwise unavailable.

History: En. 14-618 by Sec. 18, Ch. 38, L. 1975; R.C.M. 1947, 14-618; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 90, Ch. 483, L. 2001; amd. Sec. 16, Ch. 237, L. 2003.

Cross-References

Director of Department of Administration, 32-3-201.

32-3-308. Members who leave field. Members who leave the field of membership may be permitted to retain their membership in the credit union as a matter of general policy of the board of directors.

History: En. 14-619 by Sec. 19, Ch. 38, L. 1975; R.C.M. 1947, 14-619.

Cross-References

Duties of directors, 32-3-422.

32-3-309. Liability of members. The members of the credit union shall not be personally or individually liable for the payment of its debts.

History: En. 14-620 by Sec. 20, Ch. 38, L. 1975; R.C.M. 1947, 14-620.

32-3-310. Meetings of members. (1) The annual meeting and any special meetings of the members of the credit union must be held at the time, place, and in the manner indicated by the bylaws.

(2) At all meetings a member has only one vote, irrespective of the member's shareholdings. A member may not vote by proxy, but a member may vote by absentee ballot or mail ballot if the bylaws of the credit union so provide.

(3) A society, association, partnership, or corporation having membership in the credit union may be represented and have its vote cast by one of its members or shareholders, provided that the person has been fully authorized by the organization's governing body.

(4) The board of directors may establish a minimum age, not greater than 18 years of age, as a qualification of eligibility to vote at meetings of the members or to hold office, or both.

History: En. 14-621 by Sec. 21, Ch. 38, L. 1975; R.C.M. 1947, 14-621; amd. Sec. 17, Ch. 237, L. 2003.

Cross-References

Adult rights, Art. II, sec. 14, Mont. Const.

Banks and trust companies — selection of officers and employees — meetings and minutes, 32-1-325.

Mutual savings and loan associations — directors — meetings — officers, 32-2-819.

Minors and adults defined, 41-1-101.

32-3-311 through 32-3-320 reserved.

32-3-321. Liquidation. (1) A credit union may elect to dissolve voluntarily and liquidate its affairs in the manner prescribed in this section.

(2) The board of directors shall adopt a resolution recommending the credit union be dissolved voluntarily and directing that the question of liquidation be submitted to the members.

(3) Within 14 days after the board of directors decides to submit the question of liquidation to the members, the presiding officer of the board shall notify the department of administration in writing, setting forth the reasons for the proposed action and a plan for liquidation. Within 14 days after the members act on the question of liquidation, the presiding officer of the board shall notify the department in writing as to whether or not the members approved the proposed liquidation.

(4) Depending on the credit union's circumstances, a proposed liquidation plan may or may not require the suspension of payment on shares, withdrawal of shares, transfer of shares to loans and interest, investments of any kind, loans, or other similar financial transactions. On approval of the proposal by the members, all business transactions must be permanently discontinued. Necessary expenses of operation must continue to be paid on authorization of the liquidating agent or committee during the period of liquidation.

(5) For a credit union to enter voluntary liquidation, approval by a majority of the members in writing or by a two-thirds majority of the members present at a regular or special meeting of the members is required. If authorization for liquidation is to be obtained at a meeting of the members, notice in writing must be given to each member at least 14 days prior to the meeting.

(6) If liquidation is approved, the board of directors shall appoint a liquidating agent or committee for the purpose of conserving and collecting assets, closing the affairs of the credit union, and distributing the assets as required by this chapter.

(7) A liquidating credit union shall continue in existence for the purpose of discharging its debts, collecting and distributing its assets, and doing all acts required in order to wind up its business. The liquidating credit union may sue and be sued for the purpose of enforcing debts and obligations until its affairs are fully adjusted.

(8) The liquidating agent or committee shall distribute the assets of the credit union or the proceeds of any disposition of the assets in the sequence described in 32-3-205(6).

(9) As soon as the liquidating agent or committee determines that all assets from which there is a reasonable expectancy of realization have been liquidated and distributed as set forth in this section, the liquidating agent or committee shall execute a certificate of dissolution on a form prescribed by the department. The form, together with all pertinent records of the liquidating credit union, must be filed with the department and the secretary of state. Upon filing with both entities, the credit union is dissolved.

(10) If the department determines that the liquidating agent or committee has failed to make reasonable progress in the liquidating of the credit union's affairs and distribution of its assets or has violated a provision of this chapter, the department may issue a cease and desist order against the liquidating agent or committee and appoint a new liquidating agent to complete the liquidation under the department's direction and control. The department shall fill any vacancy caused by the resignation, death, illness, removal, desertion, or incapacity to function of the liquidating agent.

History: En. 14-665 by Sec. 65, Ch. 38, L. 1975; amd. Sec. 33, Ch. 71, L. 1977; R.C.M. 1947, 14-665; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 91, Ch. 483, L. 2001; amd. Sec. 18, Ch. 237, L. 2003; amd. Sec. 3, Ch. 317, L. 2015.

Cross-References
Banks and trust companies — dissolution and disincorporation, 32-1-501.
Mutual savings and loan associations — dissolution and disincorporation, 32-2-1001.

32-3-322. Merger. (1) Any credit union may, with the approval of the department of administration, merge with another credit union under the existing charter of the other credit union, pursuant to any plan agreed upon by the majority of the board of directors of each credit union joining in the merger and approved by the affirmative vote of a majority of the voting members of the merging credit union.

(2) After agreement by each board of directors and approval by the members of the merging credit union, the president and secretary of the credit union shall execute a certificate of merger, which must set forth all of the following:

(a) the time and place of the meeting of each board of directors at which the plan was agreed upon;

(b) the vote in favor of the adoption of the plan;

(c) a copy of the resolution or other action by which the plan was agreed upon;

(d) the time and place of the meeting of the members at which the plan agreed upon was approved; and

(e) the vote by which the plan was approved by the members.

(3) The certificate and a copy of the agreed-upon plan of merger must be forwarded to the department, certified by the department, and returned to both credit unions within 30 days. A copy of the certificate of merger, the certified plan, and the articles of merger must be filed with the secretary of state by the surviving credit union.

(4) Upon return of the certificate from the department, all property rights and members' interest of the merged credit union vest in the surviving credit union without deed, endorsement, or other instrument of transfer, and all debts, obligations, and liabilities of the merged credit union are considered to have been assumed by the surviving credit union under whose charter the merger was effected. The rights and privileges of the members of the merged credit union remain intact.

(5) This section must be construed, whenever possible, to permit a credit union chartered under any other law to merge with one chartered under this chapter or to permit one chartered under this chapter to merge with one chartered under any other law.

History: En. 14-666 by Sec. 66, Ch. 38, L. 1975; R.C.M. 1947, 14-666; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 92, Ch. 483, L. 2001; amd. Sec. 19, Ch. 237, L. 2003; amd. Sec. 4, Ch. 317, L. 2015.

Cross-References
Consolidation or merger of banks, 32-1-371.

32-3-323. Conversion of charter. (1) A credit union chartered under the laws of this state may be converted to a credit union chartered under the laws of any other state or under the laws of the United States, subject to regulations issued by the department of administration.

(2) A credit union chartered under the laws of the United States or of any other state may convert to a credit union chartered under the laws of this state. To effect a conversion, a credit union shall comply with all the requirements of the jurisdiction under which it was originally chartered and the requirements of the department and file proof of compliance with the department.

History: En. 14-667 by Sec. 67, Ch. 38, L. 1975; R.C.M. 1947, 14-667; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 93, Ch. 483, L. 2001; amd. Sec. 20, Ch. 237, L. 2003.

Cross-References
Change from state to national bank, 32-1-361.

Part 4
Operation and Officers

Part Cross-References
Authorized activities of credit unions, 32-3-206.

32-3-401. General powers. A credit union may:

(1) make contracts as provided for in this chapter;

(2) sue and be sued;

(3) adopt and use a common seal and alter the seal;

(4) acquire, lease, hold, and dispose of property, either in whole or in part, necessary or incidental to its operations;

(5) at the discretion of the board of directors, require the payment of an entrance fee or annual membership fee, or both, of any person admitted to membership;

(6) receive savings from its members in the form of shares or special-purpose thrift accounts;

(7) lend its funds to its members as provided in this chapter;

(8) borrow from any source up to 50% of total assets, after deduction of the notes payable account;

(9) discount and sell any eligible obligations, subject to rules prescribed by the department of administration;

(10) sell all or substantially all of its assets or purchase all or substantially all of the assets of another credit union, subject to the approval of the department;

(11) invest surplus funds as provided in this chapter;

(12) make deposits in legally chartered banks, savings banks, cooperative banks, building and loan associations, savings and loan associations, trust companies, and corporate credit unions;

(13) assess charges to members in accordance with the bylaws for failure to meet promptly their obligations to the credit union;

(14) hold membership in other credit unions organized under this chapter or other laws and in other associations and organizations composed of credit unions;

(15) declare dividends and pay interest refunds to borrowers as provided in this chapter;

(16) collect, receive, and disburse money in connection with the sale of negotiable checks, money orders, and other money type instruments and for other purposes that provide benefit or convenience to its members and charge a reasonable fee for the services;

(17) perform tasks and missions that are requested by the federal government or this state or any agency or political subdivision of the federal government or this state, if approved by the board of directors and if not inconsistent with this chapter;

(18) contribute to, support, or participate in any nonprofit service facility whose services will benefit the credit union or its membership, subject to regulations prescribed by the department;

(19) make donations or contributions to any civic, charitable, or community organizations as authorized by the board of directors, subject to regulations prescribed by the department;

(20) purchase or make available insurance for its directors, officers, agents, employees, and members;

(21) act as custodian or trustee of individual retirement accounts, as custodian or trustee of pension funds of self-employed individuals or of the sponsor of the credit union, or as custodian or trustee under any other pension or profit-sharing plan if the funds of the accounts are invested in shares of the credit union;

(22) act as custodian or trustee for medical care savings accounts as provided in 15-61-204 or health savings accounts if qualified as provided in 26 CFR 1.408-2; or

(23) act as fiscal agent for and receive deposits from the federal government, this state, or any agency or political subdivision of the federal government or this state.

History: En. 14-613 by Sec. 13, Ch. 38, L. 1975; R.C.M. 1947, 14-613; amd. Sec. 3, Ch. 522, L. 1985; amd. Sec. 21, Ch. 237, L. 2003; amd. Sec. 5, Ch. 317, L. 2015.

Cross-References

State Treasurer as treasurer of state agencies — deposits of money, 17-6-105.
Loans of money — interest rates, Title 31, ch. 1, part 1.
Authorized activities of credit unions, 32-3-206.
Insurance for members, 32-3-609.

32-3-402. Incidental powers. A credit union may exercise such incidental powers as are granted corporations organized under the laws of this state, including those that are necessary to enable it to promote and carry on most effectively its purposes.

History: En. 14-614 by Sec. 14, Ch. 38, L. 1975; R.C.M. 1947, 14-614.

32-3-403. Election or appointment of officials. (1) The credit union must be directed by a board, consisting of an odd number of at least five directors, to be elected at the annual membership meeting by and from the members. All members of the board shall hold office for terms that the bylaws provide.

(2) The board of directors shall appoint a supervisory committee of at least three members during the organizational meeting. Subsequent appointments must be within 30 days after each annual meeting of the members for terms that the bylaws provide. The bylaws may provide that the board of directors of the credit union serves as the supervisory committee. The duties and powers of the supervisory committee must be established by the department of administration by rule.

(3) The bylaws must provide for either:

(a) a credit committee, to be either appointed by the board of directors or elected by the members; or

(b) a credit manager, to be appointed by the board of directors.

(4) If the bylaws provide for a credit committee, the committee must consist of an odd number of at least three members, who shall serve for terms that the bylaws provide. The bylaws must specify the number of members of the credit committee and the number of credit committee members needed for a quorum.

History: En. 14-622 by Sec. 22, Ch. 38, L. 1975; R.C.M. 1947, 14-622; amd. Sec. 4, Ch. 522, L. 1985; amd. Sec. 3, Ch. 25, L. 2001; amd. Sec. 22, Ch. 237, L. 2003; amd. Sec. 6, Ch. 317, L. 2015.

Cross-References

Banks and trust companies — selection of officers and employees, 32-1-325.
Mutual savings and loan associations — directors — meetings — officers, 32-2-819.
Organization procedures, 32-3-301.
Meetings of members, 32-3-310.

32-3-404. Record of board and committee members. Within 30 days after election or appointment, a record of the names and addresses of the members of the board, committees, and all officers of the credit union must be filed with the department of administration on forms provided by the department.

History: En. 14-623 by Sec. 23, Ch. 38, L. 1975; R.C.M. 1947, 14-623; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 94, Ch. 483, L. 2001; amd. Sec. 23, Ch. 237, L. 2003.

Cross-References

Records, 32-3-204.

32-3-405. Vacancies. (1) The board of directors shall fill any vacancies occurring in the board within 60 days. An individual appointed to fill a vacancy shall serve until successors elected at the next annual meeting have qualified or as provided in the bylaws.

(2) The board shall also fill vacancies in the credit and supervisory committees within 60 days or as provided in the bylaws.

History: En. 14-624 by Sec. 24, Ch. 38, L. 1975; R.C.M. 1947, 14-624; amd. Sec. 7, Ch. 317, L. 2015.

Cross-References

Banks and trust companies — board of directors — qualifications, tenure, and vacancies, 32-1-322.

32-3-406. Compensation of officials. (1) An official of the credit union, other than the treasurer or an employee, may not be compensated for service in that position.

(2) For the purposes of this section, the following payments are allowed and are not considered compensation:

(a) necessary expenses incidental to the performance of official business of the credit union; or

(b) reasonable life, health, accident, and similar insurance protection for an official.

History: En. 14-625 by Sec. 25, Ch. 38, L. 1975; R.C.M. 1947, 14-625; amd. Sec. 1044, Ch. 56, L. 2009; amd. Sec. 8, Ch. 317, L. 2015.

Cross-References

Liability insurance for officers, 32-3-610.
Life insurance, Title 33, ch. 20.
Disability insurance, Title 33, ch. 22.

32-3-407. Conflicts of interest. A director, committee member, officer, agent, or employee of the credit union may not in any manner, directly or indirectly, participate in the deliberation upon or the determination of any question affecting the person's pecuniary interest or the pecuniary interest of any corporation, partnership, or association, other than the credit union, in which the person is directly or indirectly interested.

History: En. 14-626 by Sec. 26, Ch. 38, L. 1975; R.C.M. 1947, 14-626; amd. Sec. 1045, Ch. 56, L. 2009.

Cross-References

Standards of conduct for public employees, Title 2, ch. 2.
Purchase of obligation of bank by officer, 32-1-466.
Loans by bank to managing officer or director, 32-1-467.

32-3-408. Executive officers. (1) At their next meeting following each annual meeting of the members, the directors shall elect from their own number:

(a) a presiding officer of the board;
(b) one or more vice presiding officers of the board;
(c) a treasurer; and
(d) a secretary.

(2) The treasurer and the secretary may be the same individual.

(3) The persons so elected must be the executive officers of the corporation.

(4) The terms of the officers must be 1 year or until their successors are chosen and have duly qualified.

(5) The duties of the officers must be prescribed in the bylaws.

(6) The board of directors may employ an officer in charge of operations, whose title must be either president or general manager or president and general manager, or the board of directors may designate the treasurer or an assistant treasurer to act as general manager and be in active charge of the affairs of the credit union.

History: En. 14-627 by Sec. 27, Ch. 38, L. 1975; R.C.M. 1947, 14-627; amd. Sec. 24, Ch. 237, L. 2003.

Cross-References

Banks and trust companies — selection of officers and employees, 32-1-325.
Mutual savings and loan associations — directors — meetings — officers, 32-2-819.

32-3-409. Authority of directors. The board of directors shall have the general direction of the business affairs, funds, and records of the credit union.

History: En. 14-628 by Sec. 28, Ch. 38, L. 1975; R.C.M. 1947, 14-628.

Cross-References

Records, 32-3-204.
Authorized activities of credit unions, 32-3-206.

32-3-410. Executive committee. From the persons elected to the board, the board may appoint an executive committee of not less than three directors who may be authorized to act for the board in all respects, subject to such conditions and limitations as are prescribed by the board.

History: En. 14-629 by Sec. 29, Ch. 38, L. 1975; R.C.M. 1947, 14-629.

32-3-411. Meetings of board of directors and committees. (1) Either the board of directors or the executive committee shall meet each month. The board of directors or the executive committee may meet at other times as necessary.

(2) Unless specifically prohibited by the bylaws, directors and members of the supervisory committee or credit committee may participate in and act at any meeting of the board or the supervisory or credit committee through the use of communications equipment that enables all persons participating in the meeting to communicate with each other. Participation in the meeting in this manner constitutes attendance.

(3) Unless specifically prohibited by the bylaws, any action required by this chapter to be taken at a meeting of the board of directors or a committee or any other action that may be taken at a meeting of the board of directors or a committee may be taken without a meeting if a consent in writing setting forth the action taken is signed by all the directors of the board or the committee members entitled to vote with respect to the subject matter of the action taken. The written consents must be evidenced by one or more written approvals, each of which sets forth the action taken and bears the signature of one or more board directors or committee members. All the approvals evidencing the consent must be delivered to the secretary to be filed in the corporate records of the credit union. The action taken is effective when all the directors or committee members have approved the consent unless the consent specifies a different effective date. A consent signed by all the directors or committee members has the same effect as a unanimous vote and may be stated as a unanimous vote in any document filed with the department under this chapter.

History: En. 14-630 by Sec. 30, Ch. 38, L. 1975; R.C.M. 1947, 14-630; amd. Sec. 25, Ch. 237, L. 2003.

Cross-References

Banks and trust companies — selection of officers and employees — meetings and minutes, 32-1-325.
Mutual savings and loan associations — directors — meetings — officers, 32-2-819.

32-3-412. Repealed. Sec. 2, Ch. 117, L. 2015.

History: En. 14-631 by Sec. 31, Ch. 38, L. 1975; amd. Sec. 45, Ch. 359, L. 1977; R.C.M. 1947, 14-631; amd. Sec. 5, Ch. 522, L. 1985; amd. Sec. 26, Ch. 237, L. 2003.

32-3-413. Repealed. Sec. 14, Ch. 317, L. 2015.

History: En. 14-632 by Sec. 32, Ch. 38, L. 1975; R.C.M. 1947, 14-632.

32-3-414. Repealed. Sec. 14, Ch. 317, L. 2015.

History: En. 14-633 by Sec. 33, Ch. 38, L. 1975; R.C.M. 1947, 14-633; amd. Sec. 27, Ch. 237, L. 2003.

32-3-415. Repealed. Sec. 14, Ch. 317, L. 2015.

History: En. 14-634 by Sec. 34, Ch. 38, L. 1975; R.C.M. 1947, 14-634.

32-3-416. Credit committee or credit manager duties. (1) A credit union may use a credit committee or a credit manager to approve or disapprove loans under conditions the board of directors prescribes.

(2) The credit committee or the credit manager may appoint one or more loan officers with the power to approve loans, subject to limitations or conditions that the board of directors prescribes. The board of directors shall provide an appeal process for applications rejected by loan officers.

(3) If a credit union uses a credit committee, a quorum of the credit committee shall meet as often as required to consider loan applications. A majority of the credit committee members who are present at the meeting at which an application is considered is required for approval of the application.

(4) Credit union policies set by the board of directors may determine the loan size or type of loans that a credit committee or credit manager may approve.

History: En. 14-635 by Sec. 35, Ch. 38, L. 1975; R.C.M. 1947, 14-635; amd. Sec. 1046, Ch. 56, L. 2009; amd. Sec. 9, Ch. 317, L. 2015.

Cross-References

Loan application, 32-3-602.
Loan limit, 32-3-603.

32-3-417. Audits. (1) The board of directors or supervisory committee shall make or cause to be made a comprehensive annual audit of the books and affairs of the credit union and shall submit a report of that audit to the board of directors and a summary of that report to the members at the next annual meeting of the credit union. The board or committee shall make or cause to be made any supplementary audits or examinations as it considers necessary or as are required by the department of administration or by the board of directors and submit reports of these supplementary audits to the board of directors.

(2) The board of directors or supervisory committee shall verify the records of the credit union consistent with 12 CFR 715.8 and 12 CFR 741.202.

History: En. 14-636 by Sec. 36, Ch. 38, L. 1975; R.C.M. 1947, 14-636; amd. Sec. 6, Ch. 522, L. 1985; amd. Sec. 28, Ch. 237, L. 2003; amd. Sec. 10, Ch. 317, L. 2015.

Cross-References

Reports, 32-3-202.
Examinations, 32-3-203.
Records, 32-3-204.

32-3-418. Suspension and removal of officials. (1) The supervisory committee by a unanimous vote may suspend any official until the next membership meeting, which must be held not less than 7 or more than 21 days after the suspension. At the meeting, the suspension must be acted upon by the members.

(2) Any member of the supervisory committee may be removed by the board of directors for failure to perform the member's duties in accordance with this chapter, the articles of incorporation, or the bylaws.

History: En. 14-637 by Sec. 37, Ch. 38, L. 1975; R.C.M. 1947, 14-637; amd. Sec. 1047, Ch. 56, L. 2009; amd. Sec. 11, Ch. 317, L. 2015.

Cross-References

Banks and trust companies — removal of directors, officers, or employees, 32-1-468.
Removal of directors or officers of financial institutions, Title 32, ch. 1, part 9.
Mutual savings and loan associations — removal of directors, officers, or employees — hearing, 32-2-936.

32-3-419. Calling of special meeting. The supervisory committee by a majority vote may call a special meeting of the members to consider any violation of this chapter, the credit union's charter or bylaws, or any practice of the credit union deemed by the supervisory committee to be unsafe or unauthorized.

History: En. 14-638 by Sec. 38, Ch. 38, L. 1975; R.C.M. 1947, 14-638.

Cross-References

Meetings of members, 32-3-310.

32-3-420 and 32-3-421 reserved.

32-3-422. Duties of directors — rulemaking. (1) General duties of directors include but are not limited to:

(a) acting in good faith, in a manner the directors reasonably believe to be in the best interests of the credit union's membership, with the care, including reasonable inquiry, that an ordinarily prudent director in a like position would exercise under similar circumstances;

(b) administering the affairs of the credit union fairly and impartially; and

(c) having, or achieving within 6 months after appointment or election, a working knowledge of:

(i) basic finance and accounting practices and principles, including the ability to read and understand the credit union's balance sheet and income statement and the ability to ask substantive questions of management and auditors commensurate with the size and complexity of the credit union's operations; and

(ii) the primary types of significant risks associated with credit union operations and a general knowledge of managing risks.

(2) Nondelegable duties of directors pertaining to the general direction and control of the credit union include:

(a) (i) determining the maximum number and classes of shares;

(ii) setting the par value of the shares of the credit union; and

(iii) limiting the number of shares that may be owned by a member, which must apply equally to all members;

(b) declaring dividends on shares in the manner and form provided in the bylaws;

(c) establishing a detailed written policy concerning interest refunds to members based on credit union income. The interest refunds must be in proportion to the interest paid by members on classes of loans during a fixed period that must coincide with the credit union's dividend period.

(d) approving an annual operating budget for the credit union;

(e) authorizing the employment of and fixing the compensation, if any, of the general manager;

(f) suspending or removing a member of the credit committee or supervisory committee for failure to perform duties. If the credit committee or supervisory committee is elected by the membership of the credit union under its bylaws and 32-3-403, the board of directors shall appoint a member to fill a vacancy created under this subsection (2)(f) to serve until election and qualification of the successor by the members at the next annual meeting of the membership or at a special meeting called for that purpose.

(g) borrowing money to carry on the functions of the credit union;

(h) fixing, from time to time, the maximum amount of credit that may be extended or the maximum amount that may be loaned to any one member within the limits of 32-3-603;

(i) lending money to members and establishing, by loan class or type of credit extension, a detailed written policy containing standards and conditions for approving credit applications, identifying acceptable loan purposes, establishing loan underwriting standards, and establishing maximum maturities, terms of repayment or amortization of loans, and standards pertaining to collections and charge-offs;

(j) approving the charge-off of credit union losses;

(k) terminating or suspending memberships and expelling members following a procedure that is fair and reasonable;

(l) designating persons or management positions authorized to execute or certify documents or records other than deposit account transactions on the credit union's behalf;

(m) designating a depository or depositories for the funds of the credit union and designating the persons or positions authorized to execute the credit union's deposit account transactions;

(n) authorizing the conveyance of property;

(o) appointing any special committees considered necessary;

(p) purchasing a blanket fidelity bond to protect the credit union against losses caused by occurrences covered by the bond such as fraud, dishonesty, forgery, theft, misappropriation, misapplication, or unfaithful performance of duty by a director, officer, employee, member of a duly appointed committee, or other agent of the credit union;

(q) performing other duties as the members occasionally direct; and

(r) performing or authorizing any action not inconsistent with this chapter and not specifically reserved by the bylaws for the members.

(3) A credit union's directors shall adopt written policies that include standards, conditions, and controls governing the following operational functions, any of which may be delegated to an appointed committee or qualified person to be executed consistent with the policies:

(a) acting on applications for membership and making a written record of the basis for each approval or denial of membership. The notification to an applicant of the decision made by an appointed membership committee or qualified person must include notice of the opportunity to appeal an adverse decision to the board of directors and must state the procedure and time period for commencing an appeal.

(b) investing surplus funds; and

(c) determining, from time to time, the interest rate or rates to be charged on loans and extensions of credit, consistent with credit union safety and soundness principles, by classes of loans, loan sizes, terms or maturities of loans, reference indexes, and other factors the board of directors considers appropriate.

(4) The department of administration may adopt rules necessary to implement this section.

History: En. Sec. 1, Ch. 117, L. 2015.

Part 5
Shares and Accounts

32-3-501. Shares. (1) The capital of a credit union consists of the payments by the members on shares.

(2) Shares may be subscribed to, paid for, and transferred in a manner as the bylaws prescribe.

(3) A certificate need not be issued to denote ownership of a share in a credit union.

(4) This chapter does not restrict or prohibit the issuance of shares in any type of account described in Title 72, chapter 6, part 2. However, the party, the beneficiary, or the agent of an account may not vote, obtain loans, hold office, or be required to pay an entrance or membership fee unless the party, beneficiary, or agent is a member of the credit union.

History: En. 14-639 by Sec. 39, Ch. 38, L. 1975; R.C.M. 1947, 14-639; amd. Sec. 132, Ch. 494, L. 1993.

Cross-References

Organization procedure, 32-3-301.
Form of articles and bylaws, 32-3-302.
General powers of credit unions, 32-3-401.

32-3-502. Dividends. At the intervals and for the periods that the board of directors authorizes and after providing for the required reserves, the board of directors may declare dividends to be paid from the undivided earnings at the rates and upon the classes of shares that the board determines. The dividends must be paid on all shares according to any method of calculation allowed by law.

History: En. 14-640 by Sec. 40, Ch. 38, L. 1975; R.C.M. 1947, 14-640; amd. Sec. 1, Ch. 365, L. 1997; amd. Sec. 4, Ch. 25, L. 2001.

Cross-References

Duties of directors, 32-3-422.

32-3-503. Thrift accounts. Christmas clubs, vacation clubs, and other thrift accounts may be operated under conditions established by the board of directors.

History: En. 14-641 by Sec. 41, Ch. 38, L. 1975; R.C.M. 1947, 14-641.

Cross-References

Duties of directors, 32-3-422.

32-3-504. Minors' accounts. Shares may be issued to a minor who may withdraw the shares including the dividends and interest thereon. Share payments made by a minor and withdrawals thereof by the minor shall be valid in all respects. For such purposes a minor is deemed of full age.

History: En. 14-642 by Sec. 42, Ch. 38, L. 1975; R.C.M. 1947, 14-642.

Cross-References

Rights of persons not adults, Art. II, sec. 15, Mont. Const.
Banks and trust companies — deposit in name of minor, 32-1-444.
Mutual savings and loan associations — deposit in name of minor, 32-9-917.
Power of minors to contract, Title 41, ch. 1, part 3.

32-3-505. Joint accounts. (1) A member may designate any person or persons to hold shares and thrift club accounts with the member in joint tenancy with the right of survivorship, as a tenant in common, or under any other form of multiple-party account ownership permitted by law and allowed by the credit union. A joint tenant, unless a member in the joint tenant's own right, may not be permitted to vote, obtain loans, or hold office or be required to pay an entrance or membership fee. If a credit union allows more than one joint owner to seek credit union membership through a joint account, the joint account must contain a membership share for each joint owner seeking membership.

(2) Payment of part or all of a joint account to any of the joint owners, to the extent of the payment, discharges the liability to all joint owners.

History: En. 14-643 by Sec. 43, Ch. 38, L. 1975; R.C.M. 1947, 14-643; amd. Sec. 29, Ch. 237, L. 2003.

Cross-References

Joint tenancy — how created, 70-20-105.

32-3-506. Shares in trust. (1) Shares may be issued in the name of a revocable trust if the settlor is a member, or shares may be issued in the name of an irrevocable trust if either the settlor or the beneficiary is a member. A beneficiary, unless a member in the beneficiary's own right, may not be permitted to vote, obtain loans, or hold office or be required to pay an entrance or membership fee.

(2) Payment of part or all of the shares described in subsection (1) to a trustee, to the extent of the payment, discharges the liability of the credit union to the trustee and the beneficiary, and the credit union is not obligated to see to the application of the payment.

History: En. 14-644 by Sec. 44, Ch. 38, L. 1975; R.C.M. 1947, 14-644; amd. Sec. 30, Ch. 237, L. 2003; amd. Sec. 144, Ch. 264, L. 2013.

Cross-References

Trust Code, Title 72, ch. 38.

32-3-507. Liens. The credit union has a lien on the shares and accumulated dividends or interest of a member in the member's individual, joint, or trust account for any sum past due the credit union from the member or for any loan endorsed by the member.

History: En. 14-645 by Sec. 45, Ch. 38, L. 1975; R.C.M. 1947, 14-645; amd. Sec. 1048, Ch. 56, L. 2009.

Cross-References

Liens, Title 71, ch. 3.

32-3-508. Dormant accounts. When administering member accounts that are dormant, unclaimed, or abandoned, a credit union shall comply with the Uniform Unclaimed Property Act provided for in Title 70, chapter 9, part 8.

History: En. 14-646 by Sec. 46, Ch. 38, L. 1975; R.C.M. 1947, 14-646; amd. Sec. 31, Ch. 237, L. 2003.

32-3-509. Reduction in shares. (1) Whenever the losses of any credit union, resulting from a depreciation in value of its loans or investments or otherwise, exceed its undivided earnings and reserve fund so that the estimated value of its assets is less than the total amount due the shareholders, the credit union may by a majority vote of the entire membership order a reduction in the shares of each of its shareholders to divide the loss proportionately among the members.

(2) If the credit union thereafter realizes from such assets a greater amount than was fixed by the order of reduction, such excess shall be divided proportionately among the shareholders whose assets were reduced, but only to the extent of such reduction.

History: En. 14-647 by Sec. 47, Ch. 38, L. 1975; R.C.M. 1947, 14-647.

Cross-References

Meetings of members, 32-3-310.

32-3-510. Withdrawals. Shares may be withdrawn for payment to the account holder or to third parties in such manner and in accordance with such procedures as may be established by the board of directors.

History: En. Sec. 8, Ch. 522, L. 1985.

Cross-References

Authorized activities of credit unions, 32-3-206.

Part 6
Loans and Insurance

32-3-601. Repealed. Sec. 14, Ch. 317, L. 2015.

History: En. 14-648 by Sec. 48, Ch. 38, L. 1975; R.C.M. 1947, 14-648; amd. Sec. 6, Ch. 275, L. 1981; amd. Sec. 1, Ch. 9, L. 1983; amd. Sec. 32, Ch. 237, L. 2003.

32-3-602. Loan application. Every application for a loan must be made upon a form prescribed by the credit union. The application must state the security, if any, offered. Each loan must be evidenced by a written document or electronic data capable of being converted into written form.

History: En. 14-649 by Sec. 49, Ch. 38, L. 1975; R.C.M. 1947, 14-649; amd. Sec. 5, Ch. 25, L. 2001; amd. Sec. 33, Ch. 237, L. 2003.

32-3-603. Loan limit. No loan shall be made to any member in an aggregate amount in excess of 10% of the credit union's total assets.

History: En. 14-650 by Sec. 50, Ch. 38, L. 1975; R.C.M. 1947, 14-650.

Cross-References

Banks and trust companies — limitations on loans, 32-1-432.
Duties of directors, 32-3-422.

32-3-604. Security — real property loans. (1) In addition to generally accepted types of security, the endorsement of a note by a surety, comaker, or guarantor or pledge of shares, in a manner consistent with the laws of this state, must be considered security within the meaning of this chapter. The adequacy of any security is subject to the lending policies established by the board of directors.

(2) A credit union that is subject to the provisions of this part may not require a borrower, as a condition of obtaining or maintaining a loan secured by real property, to provide insurance on improvements to real property in an amount that exceeds the reasonable replacement value of the improvements.

History: En. 14-651 by Sec. 51, Ch. 38, L. 1975; R.C.M. 1947, 14-651; amd. Sec. 34, Ch. 237, L. 2003; amd. Sec. 2, Ch. 324, L. 2009.

Cross-References

Guaranty, indemnity, and suretyship, Title 28, ch. 11.
Banks — giving security for deposit prohibited — exceptions, 32-1-447.
Credit committee or credit manager, 32-3-416.

32-3-605. Installments. A member may receive a loan in installments or in one sum and may pay the whole or any part of the loan on any day on which the office of the credit union is open for business.

History: En. 14-652 by Sec. 52, Ch. 38, L. 1975; R.C.M. 1947, 14-652; amd. Sec. 1049, Ch. 56, L. 2009.

Cross-References

Montana Retail Installment Sales Act, Title 31, ch. 1, part 2.

32-3-606. Line of credit. Upon their own motion or upon application by a member, the credit committee or credit manager may approve a line of credit in advance, and advances may be granted to each member within the limit of such extension of credit. Where a line of credit has been approved, no additional loan applications are required as long as the aggregate obligation does not exceed the limit of such extension of credit.

History: En. 14-653 by Sec. 53, Ch. 38, L. 1975; R.C.M. 1947, 14-653.

Cross-References

U.C.C. — letters of credit, Title 30, ch. 5.

Loan limit, 32-3-603.

32-3-607. Other loan programs. (1) A credit union may participate in loans to credit union members jointly with other credit unions, corporations, or financial organizations.

(2) A credit union may participate in guaranteed loan programs of the federal and state government.

(3) A credit union may purchase the conditional sales contracts, notes, and similar instruments of its members.

History: En. 14-654 by Sec. 54, Ch. 38, L. 1975; R.C.M. 1947, 14-654.

Cross-References

Student loan program, Title 20, ch. 26, part 11.

Montana Retail Installment Sales Act, Title 31, ch. 1, part 2.

32-3-608. Loans to officials. (1) (a) Except as provided in subsection (1)(b), a credit union may make loans to its officials if:

(i) the loan complies with the requirements of this chapter with respect to loans to other borrowers and is not on terms more favorable than those extended to other borrowers; and

(ii) the loan or aggregate of loans to any one official that exceeds $20,000 plus pledged shares is reported to the board of directors. Loans to officials may not exceed an aggregate of 20% of unimpaired capital of the credit union.

(b) Employees other than officials may receive loans more favorable than those extended to other borrowers, including low-interest or no-interest loans.

(2) A credit union may permit directors, loan officers, the credit manager, and members of its supervisory and credit committees to act as comakers, guarantors, or endorsers of loans to other members. If the loan standing alone or when added to any outstanding loan or loans to the comaker, guarantor, or endorser exceeds $20,000, a report to the board of directors is required.

History: En. 14-655 by Sec. 55, Ch. 38, L. 1975; R.C.M. 1947, 14-655; amd. Sec. 2, Ch. 365, L. 1997; amd. Sec. 35, Ch. 237, L. 2003; amd. Sec. 12, Ch. 317, L. 2015.

Cross-References

Guaranty, Title 28, ch. 11, parts 1 and 2.

Banks and trust companies — loans to managing officer or director, 32-1-467.

32-3-609. Insurance for members — debt cancellation and suspension programs. (1) A credit union may purchase or make available insurance for its members in amounts related to their respective ages, shares, or loan balances or to any combination of them.

(2) A credit union may, upon application to and approval by the department of administration pursuant to 32-3-206, offer debt cancellation and suspension programs. Debt cancellation or suspension programs offered pursuant to this subsection are not insurance products subject to the provisions of Title 33. The department shall adopt rules to implement this subsection that must be substantially equivalent to or more stringent than federal laws, regulations, and regulatory guidelines that are applicable to debt cancellation or suspension programs offered by federal credit unions.

History: En. 14-656 by Sec. 56, Ch. 38, L. 1975; R.C.M. 1947, 14-656; amd. Sec. 2, Ch. 138, L. 2011.

Cross-References

General powers of credit union, 32-3-401.

Authorization of insurers — certificate of authority required, 33-2-101.

32-3-610. Liability insurance for officers. A credit union may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the credit union or who is or was serving at the request of the credit union as a director, officer, employee, or agent of another corporation, partnership, joint venture, trust, or other enterprise against any liability asserted against such person and incurred by such person in any such capacity or arising out of such person's status as such, whether or not the credit union would have the power to indemnify such person against such liability.

History: En. 14-657 by Sec. 57, Ch. 38, L. 1975; R.C.M. 1947, 14-657.

Cross-References

Indemnity, Title 28, ch. 11, part 3.

Suretyship insurance, Title 33, ch. 26.

32-3-611. Share insurance. (1) Each credit union shall maintain insurance on its share accounts under the provisions of Title II of the Federal Credit Union Act or through a legally constituted insurance plan approved by the commissioner of insurance and the department of administration.

(2) A credit union may not begin operation or transact any business until proof that it has obtained insurance under the provisions of Title II of the Federal Credit Union Act or under an approved insurance plan has been furnished to the department.

(3) A credit union operating in violation of this section is subject to an order of suspension as provided for in 32-3-205.

(4) Subject to the provisions of 32-3-207, the department shall make available reports of condition and examination reports to the national credit union administration or any official of an insurance plan and may accept any report of examination made on behalf of the national credit union administration or insurance plan official. The department may appoint the national credit union administration or any official of an insurance plan as liquidating agent of an insured credit union.

History: En. 14-658 by Sec. 58, Ch. 38, L. 1975; R.C.M. 1947, 14-658; amd. Sec. 7, Ch. 36, L. 1979; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 7, Ch. 522, L. 1985; amd. Sec. 95, Ch. 483, L. 2001; amd. Sec. 36, Ch. 237, L. 2003; amd. Sec. 22, Ch. 3, L. 2019.

Cross-References

Federal Deposit Insurance Corporation — definition of banking institution, 32-1-601.

Part 7
Investments and Reserves

32-3-701. Investment of funds — rulemaking. (1) Funds not used in loans to members may be invested in:

(a) securities, obligations, or other instruments issued by or fully guaranteed as to principal and interest by the United States of America or any agency of the United States government or in any trust established for investing directly or collectively in securities, obligations, or other instruments issued by or fully guaranteed as to principal and interest by the United States government;

(b) general obligations of any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, and the several territories organized by congress, or any political subdivisions of entities listed in this subsection (1)(b);

(c) certificates of deposit or passbook type accounts issued by a state or national bank, mutual savings bank, building and loan association, or savings and loan association;

(d) loans to or in shares or deposits of other credit unions;

(e) the capital shares, obligations, or preferred stock issues of any agency or association organized either as a stock company, mutual association, or membership corporation, provided the membership or stockholdings, as the case may be, of the agency or association are primarily confined or restricted to credit unions or organizations of credit unions and provided the purposes for which the agency or association is organized are designed primarily to service or otherwise assist credit union operations;

(f) shares of a cooperative society organized under the laws of this state or of the laws of the United States in the total amount not exceeding 10% of the shares and surplus of the credit union;

(g) loans to any credit union association or corporation, national or state, of which the credit union is a member, except that the investments authorized under this subsection (1)(g) must be limited to 2% of the assets of the credit union.

(2) A credit union may purchase, sell, underwrite, and hold other investment securities that are obligations in the form of bonds, notes, or debentures, as provided in rules adopted by the department. However, a credit union may not purchase, sell, underwrite, or hold investment securities that are derivative transactions.

(3) The department shall adopt rules to implement this section.

History: **En. 14-659 by Sec. 59, Ch. 38, L. 1975; R.C.M. 1947, 14-659; amd. Sec. 13, Ch. 317, L. 2015.**

Cross-References

Coal severance tax bonds — legal investments, 17-5-718.
Highway revenue bonds — legal investments, 17-5-930.
Economic development bonds as legal investments, 17-5-1525.
Municipal finance consolidation bonds as legal investments, 17-5-1628.
U.C.C. — investment securities, Title 30, ch. 8.
Securities regulation, Title 30, ch. 10.
Banks and trust companies — demand or time deposits, 32-1-445.
Authorized activities of credit unions, 32-3-206.
General powers of credit unions, 32-3-401.
Corporate credit unions, Title 32, ch. 3, part 8.
Cooperative associations — shares, dividends, and distributions, Title 35, ch. 15, part 4.
Trust Code, Title 72, ch. 38.
Montana Facility Finance Authority bonds — legal investment, 90-7-113.

32-3-702. Maintenance of regular reserve account. The department of administration may require a credit union to establish and maintain, at a certain level, a regular reserve account as a contingency to address potential losses. The department may rely on standards adopted by the national credit union administration (NCUA) in making any determination to require a credit union to establish a regular reserve account.

History: **En. 14-660 by Sec. 60, Ch. 38, L. 1975; R.C.M. 1947, 14-660; amd. Sec. 2, Ch. 64, L. 2003; amd. Sec. 37, Ch. 237, L. 2003.**

Cross-References

Banks allowed to join federal reserve bank, 32-1-373.

32-3-703. Use of regular reserve account. The regular reserve account belongs to the credit union and must be used to meet losses including, with prior approval of the department of administration, losses from the sale of investments or securities. The regular reserve account may not be used to meet losses resulting from an excess of expenses over income and may not be distributed except on liquidation of the credit union or in accordance with a plan approved by the department.

History: **En. 14-661 by Sec. 61, Ch. 38, L. 1975; R.C.M. 1947, 14-661; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 1, Ch. 219, L. 1983; amd. Sec. 96, Ch. 483, L. 2001; amd. Sec. 38, Ch. 237, L. 2003.**

Cross-References

Director of Department of Administration, 32-3-201.
Liquidation, 32-3-321.
Reduction in shares, 32-3-509.

32-3-704. Repealed. Sec. 3, Ch. 64, L. 2003; sec. 40, Ch. 237, L. 2003.

History: **En. 14-662 by Sec. 62, Ch. 38, L. 1975; R.C.M. 1947, 14-662; amd. Sec. 1, Ch. 4, L. 1991; amd. Sec. 42, Ch. 18, L. 1995.**

32-3-705. Special reserves. In addition to the regular reserve account, special reserves to protect the interest of members must be established:

(1) when required by regulation; or

(2) when found by the board of directors of the credit union or by the department of administration to be necessary.

History: **En. 14-663 by Sec. 63, Ch. 38, L. 1975; R.C.M. 1947, 14-663; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 97, Ch. 483, L. 2001; amd. Sec. 39, Ch. 237, L. 2003.**

Cross-References

Director of Department of Administration, 32-3-201.
Authority of directors, 32-3-409.
Duties of directors, 32-3-422.

Part 8
Corporate Credit Unions

32-3-801. Organization. A corporate credit union may be organized and operated under this chapter and is subject to all provisions not inconsistent with this part. The credit union shall use the term "corporate" in its official name.

History: **En. 14-668 by Sec. 68, Ch. 38, L. 1975; R.C.M. 1947, 14-668; amd. Sec. 1, Ch. 66, L. 1993; amd. Sec. 43, Ch. 18, L. 1995.**

32-3-802. Purpose — membership. (1) A corporate credit union must be operated primarily for the purpose of serving other credit unions.

(2) Membership in a corporate credit union must include credit unions organized and operating under this chapter or under any other credit union law.

(3) Membership may also include:

(a) officers, directors, committee members, and employees of credit unions; or

(b) organizations and associations of those persons or organizations enumerated in subsections (2) and (3)(a).

(4) The membership of a corporate credit union may not include more than seven natural persons as described in subsection (3)(a).

History: En. 14-669 by Sec. 69, Ch. 38, L. 1975; R.C.M. 1947, 14-669; amd. Sec. 2, Ch. 66, L. 1993.

Cross-References

Credit union membership defined, 32-3-304.
Other credit unions, 32-3-306.
Liquidation of credit unions, 32-3-321.
General powers of credit unions, 32-3-401.

32-3-803. Voting representative — conflict of interest. (1) Each credit union that is a member of a corporate credit union may designate one person to be its voting representative in the corporate credit union. The person must be designated by the board of directors of the member credit union. The voting representative is eligible to hold office in the corporate credit union as if the person were a member of the corporate credit union.

(2) (a) A director, committee member, officer, agent, or employee may not in any manner participate in the deliberation or determination of any question affecting that person's personal pecuniary interest.

(b) A director, officer, agent, or employee may not in any manner participate in the determination of any matter material in amount, as defined by rule by the department, affecting the pecuniary interest of any corporation, partnership, or association, other than the corporate credit union, in which that person has a direct or indirect interest, except for matters involving payment of dividends to the membership.

(3) The department shall adopt rules implementing this section in substantial conformance with Title 12, part 704, Code of Federal Regulations.

History: En. 14-670 by Sec. 70, Ch. 38, L. 1975; R.C.M. 1947, 14-670; amd. Sec. 3, Ch. 66, L. 1993; amd. Sec. 140, Ch. 42, L. 1997; amd. Sec. 3, Ch. 365, L. 1997.

Cross-References

Duties of directors, 32-3-422.

32-3-804. Additional rights and powers — department rules. (1) Except as limited by this part and rules adopted pursuant to this part, a corporate credit union has all of the rights and powers of any other credit union organized under this chapter and the additional rights and powers specified in this part.

(2) A corporate credit union may, as permitted by rules of the department, make loans to other credit unions and provide correspondent services and other financial services to other credit unions.

(3) A corporate credit union may, as permitted by rules of the department, invest in and grant loans to associations of credit unions, central funds of credit unions, or organizations chartered to provide service to credit unions.

(4) A corporate credit union may, as permitted by rules of the department, borrow and accept money from any source and issue notes or debentures.

(5) A corporate credit union may, as permitted by rules of the department, make reasonable and prudent investments.

(6) The department shall adopt rules governing corporate credit union loans, borrowing, investments, strategic planning, funds management, capital goals, and services. The rules must be in substantial conformance with Title 12, part 704, Code of Federal Regulations.

(7) A corporate credit union may issue membership capital accounts as provided in 32-3-805.

(8) A corporate credit union may issue paid-in capital and nonmember paid-in capital as provided in 32-3-810.

(9) A corporate credit union with corporate shareholdings equal to or in excess of 95% of its total assets may, by vote of its board of directors, elect exemption of insurance on share accounts under the provisions of Title II of the Federal Credit Union Act.

History: En. 14-671 by Sec. 71, Ch. 38, L. 1975; amd. Sec. 1, Ch. 111, L. 1977; R.C.M. 1947, 14-671; amd. Sec. 1, Ch. 233, L. 1979; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 4, Ch. 66, L. 1993; amd. Sec. 4, Ch. 365, L. 1997.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.
General powers of credit unions, 32-3-401.
Investment of funds, 32-3-701.

32-3-805. Membership capital accounts. (1) A corporate credit union may issue membership capital accounts to members that are available to cover losses that exceed reserves and undivided earnings and paid-in capital.

(2) (a) For purposes of this section, "membership capital account" means a share, deposit, term certificate, adjusted balance, or other account that:

(i) is established, at a minimum, as a 3-year notice account;

(ii) is limited to members;

(iii) is not subject to share insurance coverage by the national credit union share insurance fund or other deposit insurers; and

(iv) in the event of liquidation of the corporate credit union, is payable only after satisfaction of all liabilities of the liquidation estate, including uninsured obligations to shareholders and the national credit union share insurance fund.

(b) Upon written notice of intent to withdraw membership capital, the balance of the account will be frozen with no annual adjustment until the conclusion of the notice period, except in the case of a credit union that is placed into liquidation, is purchased and assumed, or is merged.

(c) Upon notification of intent to withdraw, the amount of the account on notice that may be considered membership capital is reduced by a constant monthly amortization that ensures that the recognition of membership capital is fully amortized at the end of the notice period.

(d) The full balance of a membership capital account that has been placed on notice, not just the remaining nonamortized portion, is available to absorb losses in excess of reserves and undivided earnings and of paid-in capital until the funds are released by the corporate credit union at the conclusion of the notice period.

(3) A membership capital account may not be used to pledge borrowings.

(4) Corporate credit unions that issue membership capital accounts shall disclose the terms and conditions of the account when it is opened and at least annually thereafter.

History: En. Sec. 5, Ch. 66, L. 1993; amd. Sec. 5, Ch. 365, L. 1997.

32-3-806. Fixed assets — department rules. (1) A corporate credit union may not invest in fixed assets if the aggregate of those investments would exceed 15% of capital, unless the credit union receives prior written approval from the department and the national credit union administration board.

(2) The department shall adopt rules for the administration of subsection (1) and for governing ownership of fixed assets by a corporate credit union. The rules must be in substantial conformance with Title 12, part 704, Code of Federal Regulations.

History: En. Sec. 6, Ch. 66, L. 1993.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

32-3-807. Corporate reserves — department rules. (1) A corporate credit union shall maintain a minimum capital to assets ratio according to rules adopted by the department in substantial conformance with Title 12, part 704, Code of Federal Regulations.

(2) The department shall adopt rules for the administration of subsection (1).

History: En. Sec. 7, Ch. 66, L. 1993; amd. Sec. 6, Ch. 365, L. 1997.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

32-3-808. Annual audit. (1) The supervisory committee of a corporate credit union shall require an annual opinion audit to be made by an independent, licensed certified public accountant and shall submit the audit report to the board of directors. A summary of the audit report must be submitted to the membership at the next annual meeting.

(2) The auditor's workpapers must be made available for review by state and federal regulatory examiners during any examination conducted by the examiners.

(3) A copy of the audit report and reportable conditions letter, otherwise known as the management letter, must be submitted to the department and the national credit union administration within 30 days after receipt by the board of directors.

History: En. Sec. 8, Ch. 66, L. 1993.

32-3-809. Contracts and written agreements. Services, facilities, personnel, or equipment shared with any party must be supported by a written contract or agreement that specifies the duties and responsibilities of each party and that fully supports and documents the allocation of service fees and expenses.

History: En. Sec. 9, Ch. 66, L. 1993.

32-3-810. Paid-in capital defined — authorized. (1) "Paid-in capital" means accounts or other interests of a corporate credit union that:

(a) may not exceed reserves and undivided earnings;

(b) may include both member paid-in capital and nonmember paid-in capital;

(c) are available to cover losses that exceed reserves and undivided earnings;

(d) are not insured by the national credit union share insurance fund (NCUSIF) or other share or deposit insurers;

(e) are callable only at the option of the corporate credit union and only if the corporate credit union meets its minimum level of required capital after the funds are called; and

(f) in the event of liquidation of the corporate credit union, are payable only after satisfaction of all liabilities of the liquidation estate, including uninsured share obligations to the shareholders, the NCUSIF, and membership capital holders.

(2) (a) A corporate credit union may issue paid-in capital to its members.

(b) Member paid-in capital must have an initial maturity of 20 years.

(c) A corporate credit union may not condition membership, services or prices for services on a member's ownership of paid-in capital.

(d) When a paid-in capital instrument has a remaining maturity of 5 years, the amount of the instrument that may be considered paid-in capital for the purposes of this part is reduced by a constant monthly amortization that ensures the recognition of paid-in capital is fully amortized when the instrument has a remaining maturity of 3 years.

(e) The terms and conditions of any member paid-in capital instrument must be disclosed to the recorded owner of the instrument at the time the instrument is created and at least annually thereafter.

(3) A corporate credit union may issue nonmember paid-in capital accounts. However, the corporate credit union may only issue the accounts after approval by the department and the national credit union administration (NCUA), and following an evaluation by the NCUA of the strategic purpose and financial impact of issuing the accounts, the corporate credit union's financial condition and management capabilities, the maturity and capital amortization schedules of the paid-in capital instrument; and the participation, voting, acceleration, redemption, or other rights of the holder.

History: En. Sec. 9, Ch. 365, L. 1997.

Part 9
Taxation

Part Cross-References

Taxation of corporations, Title 15, ch. 31.

32-3-901. Taxation. All credit unions organized under this or any other credit union law shall have the same immunity from state and local taxation that federal credit unions have from time to time under the laws of the United States.

History: En. 14-672 by Sec. 72, Ch. 38, L. 1975; R.C.M. 1947, 14-672.

Cross-References
Conversion of charter by credit union, 32-3-323.

32-3-902. Stock transfer taxes. The shares of any credit union shall not be subject to stock transfer taxes, either when issued or when transferred from one member to another.

History: En. 14-673 by Sec. 73, Ch. 38, L. 1975; R.C.M. 1947, 14-673.

Cross-References
Shares, 32-3-501.

32-3-903. Effect of participation in government programs. The participation by a credit union in any government program providing unemployment, social security, old-age pension, or other benefits shall not be deemed a waiver of the taxation exemption hereby granted.

History: En. 14-674 by Sec. 74, Ch. 38, L. 1975; R.C.M. 1947, 14-674.

Part 10
Penalties

Part Cross-References
What constitutes actual fraud, 28-2-405.
What constitutes constructive fraud, 28-2-406.
Banks — fraud by director, officer, or employee, 32-1-464.
Classification of offenses, 45-1-201.
Felony defined, 45-2-101.
Misdemeanor defined, 45-2-101.
Theft, 45-6-301.

32-3-1001 and 32-3-1002 reserved.

32-3-1003. Penalty for false statements or entries to books and records. (1) The department of administration may impose a fine not exceeding $50,000 on a director, an executive officer, an agent, or an employee of a credit union who willfully and knowingly:

(a) makes or subscribes a false statement of facts, statement of account, or report; or

(b) makes a false entry in the books of the credit union or knowingly subscribes or exhibits false papers with the intent to deceive a person authorized to examine the credit union.

(2) The fines must be deposited in the general fund.

History: En. Sec. 1, Ch. 480, L. 2019.

32-3-1004. Penalty for fraud by director, executive officer, agent, or employee. (1) The department of administration may impose the penalty described in subsection (2) if a director, an executive officer, an agent, or an employee of a credit union:

(a) (i) knowingly receives or takes possession of any credit union property, except in payment for a just demand; and

(ii) with the intent to defraud fails to make or to cause or direct to be made a full and true entry of the receipt or possession in its books and accounts or concurs in failing to make a material entry in its books and account;

(b) knowingly concurs in making or publishing a written report, exhibit, or statement of its affairs or pecuniary condition containing any material statement that is false; or

(c) having the custody or control of the credit union's books, willfully refuses or neglects to make a proper entry in the credit union's books as required by law, to exhibit the books, or to allow the books to be inspected and allow extracts to be taken from the books by the department.

(2) An individual who is found guilty or pleads guilty to a charge under subsection (1) may be imprisoned in a state correctional facility for a term not exceeding 5 years or be fined by the department an amount not to exceed $10,000, or both.

History: En. Sec. 2, Ch. 480, L. 2019.

32-3-1005. Theft of funds. (1) The following conditions are considered theft for which the offender, upon conviction, is to be imprisoned in a state correctional facility for a term not exceeding 20 years and fined by the department of administration an amount not to exceed $50,000:

(a) fraudulent appropriation, misapplication, or theft of the money, funds, credits, or property of a credit union, whether owned by the credit union or held in trust;

(b) fraudulent issuance or putting forth of a share certificate;

(c) fraudulent drawing of an order or bill of exchange;

(d) fraudulent acceptance or assignment of a note, bond, draft, bill of exchange, mortgage, judgment, or decree with intent to injure or defraud the credit union; or

(e) fraudulent attempt to deceive an officer of the credit union or anyone appointed to examine the affairs of the credit union.

(2) This section applies to a credit union director, officer, or employee or any person who with like intent aids or abets any individual listed under this subsection (2) in the actions listed in subsection (1).

History: **En. Sec. 3, Ch. 480, L. 2019.**

32-3-1006 and 32-3-1007 reserved.

32-3-1008. Concealing actions from directors. (1) An officer or employee of a credit union who intentionally conceals from the directors or a committee of the directors any of the actions under subsection (2) may be charged with a misdemeanor, and upon being found guilty or pleading guilty is subject for each offense to a term of not more than 12 months in the county jail or a fine by the department of administration of not more than $500, or both.

(2) The following actions intentionally concealed from the directors are violations of this chapter:

(a) providing a discount, an extension of credit, or a loan made on behalf of the credit union; or

(b) purchasing a security, selling any of the credit union's securities, or making any guarantee, repurchase agreement, or other agreement obligating the credit union.

History: **En. Sec. 4, Ch. 480, L. 2019.**

32-3-1009. False statement to obtain or extend loan. An individual may be fined by the department of administration not more than $1,000 for each false statement made:

(1) to obtain for the individual or for another person, a firm, a corporation, or an association a loan of money from a credit union;

(2) to gain an extension of time for the payment of a debt owed to the credit union; or

(3) to extend credit to a customer.

History: **En. Sec. 5, Ch. 480, L. 2019.**

32-3-1010 through 32-3-1012 reserved.

32-3-1013. Removal of directors, officers, employees — hearing. (1) A director, an officer, or an employee of a credit union who is found by the department of administration, after examination, to be negligent, dishonest, reckless, or incompetent or to have violated the provisions of this part must be removed from office by the supervisory committee of the credit union on the written order of the department.

(2) If the directors neglect or refuse to remove the director, officer, or employee and any losses accrue to the credit union by reason of the negligence, dishonesty, recklessness, or incompetency of the director, officer, or employee, the department's written order is conclusive evidence of the negligence of the directors' failure to act as required in subsection (1) in any action brought against the board of directors by a member of the credit union for recovery of losses.

(3) If the supervisory committee refuses to remove the director, officer, or employee on order of the department, the supervisory committee may file a request for hearing pursuant to the Montana Administrative Procedure Act.

History: **En. Sec. 6, Ch. 480, L. 2019.**

Cross-References

Montana Administrative Procedure Act, Title 2, ch. 4.

CHAPTER 4
DEVELOPMENT CORPORATION ACT

Part 1 — General Provisions

32-4-101. Definitions.
32-4-102. Purpose.
32-4-103. Credit of state and local governments not pledged.
32-4-104. Application of corporation law.

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32-4-208. Stock ownership and limitations.

Part 3 — Operation and Regulation

32-4-301. Powers of stockholders.
32-4-302. Membership — limitation and apportionment of loans by members.
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32-4-305. Deposit of funds.
32-4-306. Control — supervision — reports.

Chapter Cross-References

Credit Transactions and Relationships, Title 31.
Corporations, Partnerships, and Associations, Title 35.

Part 1
General Provisions

32-4-101. Definitions. As used in this chapter, the following words and phrases, unless differently defined or described, shall have the meanings and references as follows:

(1) "board of directors"—the board of directors of a corporation created under this chapter;

(2) "corporation"—a Montana development corporation created under this chapter;

(3) "financial institution"—any banking corporation or trust company, building and loan association, insurance company or related corporation, partnership, foundation, or other institution engaged primarily in lending or investing funds;

(4) "loan limit"—for any member, the maximum amount permitted to be outstanding at one time on loans made by such member to the corporation, as determined under the provisions of this chapter;

(5) "member"—any financial institution authorized to do business within this state which shall undertake to lend money to a corporation created under this chapter, upon its call and in accordance with the provisions of this chapter.

History: En. Sec. 2, Ch. 128, L. 1969; R.C.M. 1947, 15-2602; amd. Sec. 1, Ch. 320, L. 1983.

Cross-References

Definition of regulated lender, 31-1-111.

32-4-102. Purpose. (1) The purposes of the corporation shall be to:

(a) promote, stimulate, develop, and advance the business prosperity and economic welfare of the state of Montana and its citizens;

(b) encourage and assist through loans, investments, or other business transactions in the location of new business and industry in this state and to rehabilitate and assist existing business and industry;

(c) stimulate and assist in the expansion of all kinds of business activity which will tend to promote the business development and maintain the economic stability of this state, provide maximum opportunities for employment, encourage thrift, and improve the standards of living of the citizens of this state;

(d) cooperate and act in conjunction with other organizations, public or private, in the promotion and advancement of industrial, commercial, agricultural, and recreational developments in this state; and

(e) provide financing for the promotion, development, and conduct of all kinds of business activity in this state.

(2) In furtherance of such purposes and in addition to the powers conferred on business corporations by the provisions of Title 35 the corporation shall, subject to the restrictions and limitations herein contained, have the additional powers and functions enumerated herein.

History: En. Sec. 1, Ch. 128, L. 1969; R.C.M. 1947, 15-2601.

Cross-References

Economic development bonds, Title 17, ch. 5, part 15.
Development coordination — planning and economic development, Title 90, ch. 1, part 1.
Secondary industry and commercial development, Title 90, ch. 5.

32-4-103. Credit of state and local governments not pledged. Under no circumstances is the credit of the state, county, or municipal governments or their agencies or authorities pledged under this chapter.

History: En. Sec. 17, Ch. 128, L. 1969; R.C.M. 1947, 15-2617; amd. Sec. 1, Ch. 497, L. 1989.

Cross-References

State debt, Art. VIII, sec. 8, Mont. Const.
Obligations of Board of Housing — credit of state not pledged, 90-6-123.

32-4-104. Application of corporation law. The provisions of Title 35 shall apply to the corporation insofar as they may be applicable and not inconsistent with this chapter.

History: En. Sec. 18, Ch. 128, L. 1969; R.C.M. 1947, 15-2618.

Part 2
Organization

32-4-201. Incorporators — general powers — capital stock — articles of incorporation. Nine or more persons, a majority of whom must be residents of this state, who desire to create a development corporation under the provisions of this chapter for the purpose of promoting, developing, and advancing the prosperity and economic welfare of the state and, to that end, to exercise the powers and privileges provided in this part may be incorporated in the following manner:

(1) The persons shall, by articles of incorporation filed in the manner prescribed in Title 35, set forth:

(a) the name of the corporation, which must include the words "Development Corporation of Montana";

(b) the location of the principal office of the corporation, but the corporation may have offices in other places within the state as fixed by the board of directors;

(c) the purposes for which the corporation is founded, which must include the following:

(i) to elect, appoint, and employ officers, agents, and employees;

(ii) to make contracts and incur liabilities for any of the purposes of the corporation, provided that the corporation may not incur any secondary liability by way of guaranty or endorsement of obligations of any person, firm, corporation, joint-stock company, association, or trust or in any other manner;

(iii) to borrow money from members, nonmember persons, firms, or corporations and state, federal, county, or municipal agencies or authorities for any of the purposes of the corporation;

(iv) to issue for the purposes of the corporation its bonds, debentures, convertible debentures, notes, or other evidences of indebtedness, whether secured or unsecured, and to secure the indebtedness by mortgage, pledge, deed of trust, or other lien on its property, franchises, rights, and privileges of every kind and nature or any part or interest in its property, franchises, rights, and privilege, without securing stockholder or member approval. However, a loan to the corporation may not be secured in any manner unless all outstanding loans to the corporation are secured equally and ratably in proportion to the unpaid balance of the loans and in the same manner.

(v) to make loans to any person, firm, corporation, joint-stock company, association, or trust and establish and regulate the terms and conditions with respect to any loans and the charges for interest and service connected with the loans. However, the corporation may not approve any application for a loan unless the person applying for the loan shows that the person has applied for the loan through ordinary banking channels and that the loan has been refused by at least one bank or other financial institution.

(vi) to participate with any authorized private lending agency or city, county, state, or federal governmental lending agencies in the making of loans;

(vii) to purchase, receive, hold, lease, or otherwise acquire, except by condemnation, and to sell, convey, transfer, lease, or otherwise dispose of real and personal property, together with rights and privileges that may be incidental and appurtenant to the property and the use of the property, including but not restricted to any real or personal property acquired by the corporation from time to time in the satisfaction of debts or enforcement of obligations;

(viii) to acquire the goodwill, business, rights, real and personal property, and other assets or any part or interest in the assets of any persons, firms, corporations, joint-stock companies, associations, or trusts and to assume, undertake, or pay the obligations, debts, and liabilities of any person, firm, corporation, joint-stock company, association, or trust;

(ix) to acquire improved or unimproved real estate for the purpose of constructing industrial plants or other business establishments or for the purpose of disposing of real estate to others for the construction of industrial plants or other business establishments;

(x) to acquire, construct or reconstruct, alter, repair, maintain, operate, sell, convey, transfer, lease, or otherwise dispose of industrial plants or business establishments;

(xi) to acquire, subscribe for, own, hold, sell, assign, transfer, mortgage, pledge, or otherwise dispose of the stock, shares, bonds, debentures, notes, or other securities and evidences of interest in or indebtedness of any person, firm, corporation, joint-stock company, association, or trust and while the owner or holder of interest for indebtedness to exercise all the rights, powers, and privileges of ownership, including the right to vote;

(xii) to mortgage, pledge, or otherwise encumber any property, right, or thing of value, acquired pursuant to the powers contained in subsections (1)(c)(vii) through (1)(c)(xi), as security for the payment of any part of the purchase price of the property, right, or thing of value;

(xiii) to cooperate with and avail itself of the facilities of the department of commerce and any similar governmental agency and to cooperate with, assist, and otherwise encourage organizations in the various communities of the state in the promotion, assistance, and development of the business prosperity and economic welfare of the communities or of this state or of any part of the state;

(xiv) to accept gifts, donations, bequests, devises, or grants from any person, corporation, association, or governmental agency or authority, whether state, federal, county, or municipal;

(xv) to do all acts and things necessary or convenient to carry out the powers expressly granted in this chapter;

(d) the amount of total authorized capital stock and the number of shares in which it is divided, the par value of each share, the amount of capital stock with which it will commence business and, if there is more than one class of stock, a description of the different classes, and the names and post-office addresses of the subscribers of stock and the number of shares subscribed by each. The aggregate of the subscription must be the amount of capital with which the corporation will commence business.

(2) The articles of incorporation may also contain any provision consistent with the laws of this state for the regulation of the affairs of the corporation or creating, defining, limiting, and regulating its powers. The articles of incorporation must be in accordance with the provisions of Title 35, so far as they are consistent with this chapter.

History: En. Sec. 3, Ch. 128, L. 1969; amd. Sec. 34, Ch. 71, L. 1977; R.C.M. 1947, 15-2603; amd. Sec. 6, Ch. 274, L. 1981; amd. Sec. 2, Ch. 320, L. 1983; amd. Sec. 2, Ch. 497, L. 1989; amd. Sec. 98, Ch. 483, L. 2001.

Cross-References

U.C.C. — investment securities, Title 30, ch. 8.

Securities regulation, Title 30, ch. 10.

Registration of assumed business name similar to reserved or registered name or mark prohibited, 30-13-202.

Development coordination — planning and economic development, Title 90, ch. 1, part 1.

32-4-202. Duration. The period of duration of the corporation shall be perpetual.

History: En. Sec. 15, Ch. 128, L. 1969; R.C.M. 1947, 15-2615.

32-4-203. Certificate of incorporation. Before the articles of incorporation may become effective, the secretary of state shall issue a certificate that verifies that a copy of the articles containing the required statement of facts has been filed in the secretary of state's office. Upon issuance of the certificate, the persons signing the articles, their associates, and their successors and assigns become a body politic and corporate, by the name specified in the articles of incorporation, subject to amendment and dissolution as provided in this chapter. The incorporators have the authority to and shall perform the acts and things as required by the provisions of this chapter, as set forth in 32-4-201.

History: En. Sec. 4, Ch. 128, L. 1969; R.C.M. 1947, 15-2604; amd. Sec. 1050, Ch. 56, L. 2009.

32-4-204. Effect of failure to commence business. If a corporation organized pursuant to this chapter shall fail to begin business within 5 years from the effective date of its articles of incorporation, then said articles shall become null and void.

History: **En. Sec. 16, Ch. 128, L. 1969; R.C.M. 1947, 15-2616.**

32-4-205. Amendment of articles of incorporation. (1) The articles of incorporation may be amended by vote of the stockholders of the corporation, and the amendments require approval by the affirmative vote of two-thirds of the stockholders, provided:

(a) that an amendment that is inconsistent with the general purposes expressed in this chapter or that eliminates or curtails the obligation of the corporation to make reports as provided in 32-4-306 may not be made without amendment of this chapter; and

(b) that an amendment of the articles of incorporation that increases the obligation of a member to make loans to the corporation, makes any change in the principal amount, interest rate, maturity date, or in the security or credit position of any outstanding loan of a member to the corporation, or affects a member's right to withdraw from membership as provided in 32-4-303 may not be made without the consent of each member affected by the amendment.

(2) Within 30 days after any meeting at which amendment of the articles of incorporation has been adopted, articles of amendment signed and sworn to by the president, treasurer, and a majority of the directors, setting forth the amendment and the due adoption of the amendment, must so far as consistent with this chapter be submitted, as prescribed in Title 35, to the secretary of state who shall examine the articles. If the secretary of state finds that the articles conform to the requirements of this chapter, the secretary of state shall so certify and endorse approval on the amended articles. Upon certification and approval, the amended articles of incorporation must be filed in the office of the secretary of state, and an amendment may not take effect until the amended articles of incorporation have been filed as provided in this subsection.

History: **En. Sec. 5, Ch. 128, L. 1969; R.C.M. 1947, 15-2605; amd. Sec. 1, Ch. 91, L. 1987; amd. Sec. 1051, Ch. 56, L. 2009.**

32-4-206. Board of directors. (1) The business and affairs of the corporation shall be managed and conducted by a board of directors, a president and treasurer, and other officers and agents as the corporation by its bylaws shall authorize.

(2) The board of directors shall consist of a number, not less than nine, as determined in the first instance by the incorporators and thereafter annually by the stockholders of the corporation, provided that any state, county, or municipal agency or authority that has made a grant or loan to the corporation shall have at least one seat on the board of directors and additional seats representative of its proportional investment in the corporation.

(3) The directors need not be stockholders in the corporation.

(4) The board of directors may exercise all the powers of the corporation except as are conferred by law or by the bylaws of the corporation upon the stockholders and shall choose and appoint all the agents and officers of the corporation and fill all vacancies in the office of director.

(5) The board of directors shall be elected in the first instance by the incorporators and thereafter at each annual meeting of the corporation or, if no annual meeting is held in any year at the time fixed by the bylaws, at a special meeting held in lieu of the annual meeting. At each annual meeting or at each special meeting held in lieu of the annual meeting, the stockholders shall elect the directors. The directors shall hold office until the next annual meeting of the corporation or special meeting held in lieu of the annual meeting after their election and until their successors are elected and qualified, unless sooner removed in accordance with the provisions of the bylaws.

(6) Directors and officers are not responsible for losses unless the losses were occasioned by the willful misconduct of the directors and officers.

History: **En. Sec. 6, Ch. 128, L. 1969; R.C.M. 1947, 15-2606; amd. Sec. 2, Ch. 91, L. 1987; amd. Sec. 3, Ch. 497, L. 1989.**

32-4-207. First meeting of corporation. (1) The first meeting of the corporation shall be called by a notice signed by three or more of the incorporators, stating the time, place, and purpose of the meeting, a copy of which notice shall be mailed or delivered to each incorporator at least 5 days before the day appointed for the meeting. Said first meeting may be held without such notice upon agreement in writing to that effect signed by all the incorporators. There shall be recorded in the minutes of the meeting a copy of said notice or of such unanimous agreement of the incorporators.

(2) At such first meeting the incorporators shall organize by the choice by ballot of a temporary clerk, by the adoption of bylaws, by the election by ballot of directors, and by action upon such other matters within the powers of the corporation as the incorporators may see fit. The temporary clerk shall be sworn and shall make and attest a record of the proceedings. Five of the incorporators shall be a quorum for the transaction of business.

History: En. Sec. 8, Ch. 128, L. 1969; R.C.M. 1947, 15-2608.

32-4-208. Stock ownership and limitations. Notwithstanding any rule at common law or any provision of any general or special law or any provision in their respective charters, agreements of association, articles of organization, or trust indentures:

(1) all persons, domestic corporations organized for the purpose of carrying on business within this state, including without implied limitation any public utility companies and insurance and casualty companies and foreign corporations licensed to do business in the state, and trusts are hereby authorized to acquire, purchase, hold, sell, assign, transfer, mortgage, pledge, or otherwise dispose of any bonds, securities, or other evidences of indebtedness created by, or the shares of the capital stock of, the corporation and, while owners of said stock, to exercise all the rights, powers, and privileges of ownership, including the right to vote thereon, all without the approval of any regulatory authority of the state;

(2) all financial institutions are hereby authorized to become members of the corporation by making loans to the corporation as provided herein;

(3) a financial institution which does not become a member of the corporation shall not be permitted to acquire any share of the capital stock of the corporation;

(4) each financial institution which becomes a member of the corporation is hereby authorized to acquire, purchase, hold, sell, assign, transfer, mortgage, pledge, or otherwise dispose of any bonds, securities, or other evidences of indebtedness created by, or the shares of the capital stock of, the corporation and, while owners of said stock, to exercise all the rights, powers, and privileges of ownership, including the right to vote thereon, all without the approval of any regulatory authority of the state.

History: En. Sec. 9, Ch. 128, L. 1969; R.C.M. 1947, 15-2609; amd. Sec. 3, Ch. 91, L. 1987.

Cross-References

U.C.C. — investment securities, Title 30, ch. 8.
Securities regulation, Title 30, ch. 10.
Investments of financial institutions, 32-1-424.
Investment of funds of credit unions, 32-3-701.

Part 3
Operation and Regulation

32-4-301. Powers of stockholders. (1) The stockholders of the corporation have the following powers of the corporation:

(a) to determine the number of and elect directors as provided in 32-4-206;

(b) to make, amend, and repeal bylaws;

(c) to amend the articles of incorporation as provided in 32-4-205;

(d) to exercise other powers of the corporation as may be conferred on the stockholders by the bylaws.

(2) As to all matters requiring action by the stockholders of the corporation and except as otherwise provided in this chapter, the matters require the affirmative vote of a majority of the votes to which the stockholders present or represented at the meeting are entitled.

(3) Each stockholder has one vote, in person or by proxy, for each share of capital stock held by the stockholder.

History: En. Sec. 7, Ch. 128, L. 1969; R.C.M. 1947, 15-2607; amd. Sec. 4, Ch. 91, L. 1987; amd. Sec. 1052, Ch. 56, L. 2009.

32-4-302. Membership — limitation and apportionment of loans by members. Any financial institution may request membership in the corporation by making application to the board of directors on such form and in such manner as said board of directors may require, and membership shall become effective upon acceptance of such application by the board. The application for membership will specify the loan limit which shall be subject to call of the corporation, but in no case shall the amount so specified exceed the limit provided for in this chapter. Each member of the corporation shall make loans to the corporation as and when called upon by it to do so on such terms and other conditions as shall be approved from time to time by the board of directors, subject to the following conditions:

(1) All loan limits shall be established at the thousand-dollar amount nearest the amount computed in accordance with the provisions of this section.

(2) No loan to the corporation shall be made if immediately thereafter the total amount of the obligations of the corporation to its members would exceed 10 times the amount then paid in on the outstanding capital stock of the corporation.

(3) The total amount outstanding on loans to the corporation made by any member at any one time, when added to the amount of the investment in the capital stock of the corporation then held by such member, shall not exceed:

(a) 20% of the total amount then outstanding on loans to the corporation by all members, including in said total amount outstanding amounts validly called for loan but not yet loaned;

(b) the following limit, to be determined on the basis of the member's balance sheet at the close of its 1982 fiscal year and then redetermined periodically with the concurrence of the member:

(i) 3% of the capital and surplus of commercial banks and trust companies;

(ii) 1/4 of 1% of the total outstanding loans made by a building and loan association;

(iii) 2% of the capital and unassigned surplus of stock insurance companies; and

(iv) such comparable limits as may be approved by the board of directors of the corporation for other financial institutions.

(4) The board of directors, on the request of any financial institution applying for membership and with the approval of one-half of the members that are the same type of financial institution as the applicant, may authorize a different loan limit than that set forth in subsection (3)(b).

(5) Subject to subsection (3)(a) of this section, each call made by the corporation shall be prorated among the members of the corporation in substantially the same proportion that the adjusted loan limit of each member bears to the aggregate of the adjusted loan limits of all members. The adjusted loan limit of a member shall be the amount of such member's loan limit, reduced by the balance of outstanding loans made by such member to the corporation and the investment in capital stock of the corporation held by such member at the time of such call.

(6) All loans to the corporation by a member shall be evidenced by bonds, debentures, notes, or other evidences of indebtedness of the corporation, which shall be freely transferable at all times and which shall bear interest at a rate of not less than 1/4 of 1% in excess of the rate of interest determined by the board of directors to be the prime rate prevailing at the time.

History: **En. Sec. 10, Ch. 128, L. 1969; R.C.M. 1947, 15-2610; amd. Sec. 3, Ch. 320, L. 1983; amd. Sec. 1, Ch. 90, L. 1985.**

Cross-References

Interest rate limitation exemption — regulated lenders, 31-1-112.
Limitations on loans of banks, 32-1-432.
Credit unions — membership defined, 32-3-304.
Credit unions — loans, 32-3-602 through 32-3-604.
Board of directors, 32-4-206.

32-4-303. Withdrawal of membership. (1) Membership in the corporation shall be for the duration of the corporation, provided that, upon written notice given to the corporation 2 years in advance, a member may withdraw from membership in the corporation at the expiration date of such notice.

(2) A member shall not be obligated to make any loans to the corporation pursuant to calls made subsequent to the withdrawal of said member.

History: **En. Sec. 11, Ch. 128, L. 1969; R.C.M. 1947, 15-2611.**

Cross-References

Credit unions — members who leave field, 32-3-308.
Amendment of articles of incorporation, 32-4-205.

32-4-304. Surplus. Each year the corporation shall set apart as earned surplus not less than 10% of its net earnings for the preceding fiscal year until such surplus shall be equal in value to 50% of the amount paid in on the capital stock then outstanding. Whenever the amount of surplus established herein shall become impaired, it shall be built up again to the required amount in the manner provided for its original accumulation. Net earnings and surplus shall be determined by the board of directors, after providing for such reserves as said directors deem desirable, and the directors' determination made in good faith shall be conclusive on all persons.

History: En. Sec. 12, Ch. 128, L. 1969; R.C.M. 1947, 15-2612; amd. Sec. 4, Ch. 320, L. 1983.

32-4-305. Deposit of funds. (1) The corporation shall not deposit any of its funds in any banking institution unless such institution has been designated as a depository by a vote of a majority of the directors present at an authorized meeting of the board of directors, exclusive of any director who is an officer or director of the depository so designated.

(2) The corporation shall not receive money on deposit.

History: En. Sec. 13, Ch. 128, L. 1969; R.C.M. 1947, 15-2613.

Cross-References

Board of directors, 32-4-206.

32-4-306. Control — supervision — reports. The corporation is subject to the examination of the department of administration and shall make reports of its condition not less than annually to the department. The department shall make copies of the reports available to the commissioner of insurance and to the governor. The corporation shall also file an annual statement required by Title 35.

History: En. Sec. 14, Ch. 128, L. 1969; amd. Sec. 87, Ch. 431, L. 1975; R.C.M. 1947, 15-2614; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 99, Ch. 483, L. 2001.

Cross-References

Department of Administration, Title 2, ch. 15, part 10.
Commissioner of Insurance — State Auditor as ex officio, 2-15-1903.
Amendment of articles of incorporation, 32-4-205.

CHAPTER 5
CONSUMER LOAN BUSINESSES

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32-5-404. Repealed.
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32-5-408. Cease and desist orders.
32-5-409. Complaint procedure.

Part 5 — Open-End Loans (Repealed)

Chapter Cross-References

Unfair trade practices and consumer protection, Title 30, ch. 14.
Credit Transactions and Relationships, Title 31.
Insurance premium finance companies, Title 33, ch. 14.

Part 1
General Provisions

Part Cross-References

Wage brokers, Title 31, ch. 1, part 3.

32-5-101. Short title. This chapter may be cited as the "Montana Consumer Loan Act".

History: En. Sec. 1, Ch. 283, L. 1959; R.C.M. 1947, 47-201.

Cross-References

Retail installment sales, Title 31, ch. 1, part 2.

32-5-102. Definitions. For the purposes of this chapter, the following definitions apply:

(1) "Balloon payment" means any repayment option in which the borrower is required to repay the entire amount of any outstanding balance as of a specific date or at the end of a specified term and the aggregate amount of the required minimum periodic payments would not fully amortize the outstanding balance by the specific date or at the end of the loan term.

(2) (a) "Consumer loan" means credit offered or extended to an individual primarily for personal, family, or household purposes, including loans for personal, family, or household purposes that are not primarily secured by a mortgage, deed of trust, trust indenture, or other security interest in real estate.

(b) Consumer loans do not include:

(i) deferred deposit loans provided for in Title 31, chapter 1, part 7; or

(ii) residential mortgage loans as defined in 32-9-103.

(3) "Department" means the department of administration provided for in Title 2, chapter 15, part 10.

(4) "Interest" means the compensation allowed by this chapter for the use, forbearance, or detention of money.

(5) "License" means a license provided for by this chapter.

(6) "Licensee" means the person holding a license.

(7) "Person" means individuals, partnerships, associations, corporations, and all legal entities.

History: En. Sec. 2, Ch. 283, L. 1959; amd. Sec. 1, Ch. 233, L. 1971; amd. Sec. 1, Ch. 172, L. 1975; amd. Sec. 110, Ch. 431, L. 1975; R.C.M. 1947, 47-202; amd. Sec. 1, Ch. 216, L. 1979; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 1, Ch. 424, L. 1981; amd. Sec. 1, Ch. 140, L. 1983; amd. Sec. 1, Ch. 374, L. 1997; amd. Sec. 100, Ch. 483, L. 2001; amd. Sec. 7, Ch. 178, L. 2003; amd. Sec. 6, Ch. 221, L. 2003; amd. Sec. 1, Ch. 372, L. 2007; amd. Sec. 2, Ch. 317, L. 2011; amd. Sec. 1, Ch. 173, L. 2013; amd. Sec. 5, Ch. 278, L. 2013.

Cross-References

Loan of money — what constitutes, 31-1-101.

32-5-103. Engaging in business of making consumer loans restricted. (1) Except as provided in subsection (5), a person may not engage in the business of making consumer loans in any amount and contract for, charge, or receive directly or indirectly on or in connection with any loan any compensation, whether for interest, fees, other consideration, or expense, except as provided in and authorized by this chapter.

(2) A licensee may sell its business and assets to a bank, building and loan association, savings and loan association, trust company, credit union, credit association, development credit corporation, other licensee, financial holding company, or bank holding company organized pursuant to state or federal statutory authority and subject to supervision, control, or regulation by an agency of the state of Montana or an agency of the federal government. All contracts for loans and all other contracts entered into by the licensee pursuant to the provisions of this chapter that are sold and transferred to an acquiring organization continue to be governed by the provisions of this chapter.

(3) The provisions of subsection (1) apply to any person who seeks to evade its applications by any device, subterfuge, or pretense.

(4) Any loan made or collected in violation of subsection (1) by a person other than a licensee or a person exempt under subsection (5) is void, and the person does not have the right to collect, receive, or retain any principal, interest, fees, or other charges.

(5) The following are not required to comply with the provisions of this chapter:

(a) a bank, building and loan association, savings and loan association, trust company, or credit union; or

(b) a person who:

(i) makes fewer than four consumer loans a year with the person's own funds;

(ii) does not represent that the person is a licensee; and

(iii) complies with the provisions of Title 31, chapter 1, part 1.

History: En. Sec. 4, Ch. 283, L. 1959; amd. Sec. 2, Ch. 233, L. 1971; amd. Sec. 2, Ch. 172, L. 1975; R.C.M. 1947, 47-204; amd. Sec. 2, Ch. 216, L. 1979; amd. Sec. 2, Ch. 424, L. 1981; amd. Sec. 1, Ch. 103, L. 1983; amd. Sec. 2, Ch. 140, L. 1983; amd. Sec. 1, Ch. 168, L. 1985; amd. Sec. 2, Ch. 406, L. 1985; amd. Sec. 1, Ch. 18, L. 1993; amd. Sec. 2, Ch. 374, L. 1997; amd. Sec. 1, Ch. 270, L. 1999; amd. Sec. 16, Ch. 404, L. 1999; amd. Sec. 21, Ch. 455, L. 2001; amd. Sec. 2, Ch. 125, L. 2005; amd. Sec. 2, Ch. 372, L. 2007; amd. Sec. 2, Ch. 173, L. 2013; amd. Sec. 6, Ch. 278, L. 2013; amd. Sec. 1, Ch. 101, L. 2017.

Cross-References

Assignment of wages to be considered loan, 31-1-308.

Interest pawnbrokers may receive, 31-1-401.

Banks and trust companies — limitations on loans, 32-1-432.

Credit unions — loan limit, 32-3-603.

Development credit corporation — membership — limitation and apportionment of loans by members, 32-4-302.

32-5-104. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 9, Ch. 424, L. 1981.

Part 2
Licensure Requirements

32-5-201. License and renewal application fees. (1) (a) Each place of business operated under this chapter must be licensed. Licenses are nontransferable and nonassignable. The same person may obtain an additional license for each business location upon compliance with this chapter.

(b) Applications for a license or renewal must be in the form and submitted in the manner prescribed by the department.

(c) A licensee may move the licensee's place of business from one place to another upon advance notice to the department in the manner the department directs.

(d) The license application fee and license renewal fee are $500 and are nonrefundable. The license year is the calendar year. All consumer loan licenses issued under this chapter expire on December 31.

(2) The department's share of all licensing and examination fees collected pursuant to this chapter must be deposited into the state special revenue fund for the use of the department in its supervision function.

(3) The department may direct that fees charged under subsection (1)(d) be remitted to the department through a nationwide licensing system.

History: Ap. p. Sec. 6, Ch. 283, L. 1959; amd. Sec. 112, Ch. 431, L. 1975; Sec. 47-206, R.C.M. 1947; Ap. p. Sec. 5, Ch. 283, L. 1959; amd. Sec. 3, Ch. 233, L. 1971; amd. Sec. 3, Ch. 172, L. 1975; amd. Sec. 172, Ch. 431, L.

1975; Sec. 47-205, R.C.M. 1947; R.C.M. 1947, 47-205(part), 47-206; amd. Sec. 3, Ch. 216, L. 1979; amd. Sec. 3, Ch. 424, L. 1981; amd. Sec. 3, Ch. 140, L. 1983; amd. Sec. 6, Ch. 600, L. 1985; amd. Sec. 3, Ch. 372, L. 2007; amd. Sec. 3, Ch. 173, L. 2013.

Cross-References

State finance — fund structure, 17-2-102.
Discrimination in licensing prohibited, 49-3-204.

32-5-202. Issuance or denial of license or license renewal. (1) Upon submission of a completed application and payment of all required fees, a license or renewal must be issued if the department determines that:

(a) the character and general fitness of the applicant warrant the belief that the business will be operated lawfully and fairly within the provisions of this chapter;

(b) the applicant has not had a financial services license revoked by a regulatory agency in any jurisdiction;

(c) there are no outstanding civil judgments against the applicant for fraud in relation to providing consumer financial services; and

(d) the application does not contain material misstatements of fact or material omissions of fact.

(2) The department may enter an order denying the license or license renewal application subject to issuance and service of notice and opportunity for an administrative hearing as provided in 32-5-207(2).

History: En. Sec. 7, Ch. 283, L. 1959; amd. Sec. 113, Ch. 431, L. 1975; R.C.M. 1947, 47-207; amd. Sec. 4, Ch. 372, L. 2007; amd. Sec. 4, Ch. 173, L. 2013; amd. Sec. 4, Ch. 23, L. 2015.

Cross-References

Discrimination in licensing prohibited, 49-3-204.

32-5-203. Conduct of other business in same office. A licensee may conduct the business of making consumer loans under this chapter within any office, room, or place of business in which any other business for which a license under this chapter is not required is solicited or engaged in or in association or conjunction with the business. "Other business" may include making loans not primarily for personal, family, or household purposes, unless the department finds, after a hearing, that the other business is of a nature that the conduct tends to conceal evasion of this chapter or of the rules made under this chapter. If the department finds concealment or evasion, it shall order the licensee in writing to desist from the conduct.

History: En. Sec. 8, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-208; amd. Sec. 3, Ch. 374, L. 1997.

Cross-References

Wage brokers, Title 31, ch. 1, part 3.
Pawnbrokers, Title 31, ch. 1, part 4.

32-5-204. Repealed. Sec. 15, Ch. 173, L. 2013.

History: En. Sec. 9, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; amd. Sec. 35, Ch. 71, L. 1977; R.C.M. 1947, 47-209; amd. Sec. 5, Ch. 372, L. 2007.

32-5-205. Surrender of license. A license may be surrendered on conditions of the department consistent with the protocols of a nationwide licensing system for license surrender. The license surrender does not affect the licensee's civil, administrative, or criminal liability for acts committed prior to the surrender.

History: En. Sec. 21, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-221; amd. Sec. 5, Ch. 173, L. 2013.

32-5-206. Termination of license not to affect preexisting contract. No revocation, surrender, or expiration of any license shall impair or affect the obligation of any preexisting lawful contract.

History: En. Sec. 22, Ch. 283, L. 1959; R.C.M. 1947, 47-222.

Cross-References

Contracts in general, Title 28, ch. 2, 3.

32-5-207. Notice of violation — administrative hearing — penalties — liability. (1) If the department has probable cause to believe that a licensed or unlicensed person has violated this chapter, a rule promulgated under this chapter, or an order issued by the department or has made a material misrepresentation to the department by act or omission, the department may issue a notice stating the alleged violation to the person.

(2) (a) The notice referred to in subsection (1) must comply with 2-4-601 and must include a statement that the person has an opportunity to request an administrative hearing under the Montana Administrative Procedure Act within 14 days of the date that the department's notice was mailed to the person.

(b) The department's notice must be sent by certified mail to a licensee's address of record with the department or to an unlicensed person at an address for the person known to the department.

(c) The department has complied with the service of process upon mailing the notice by certified mail as provided in subsection (2)(b).

(3) If a person served with a notice under this section admits to or does not contest having violated or is found after an administrative hearing to have violated a provision of this chapter, a rule promulgated under this chapter, or an order issued by the department or to have made a material misrepresentation to the department by act or omission, the department may impose a civil penalty of not more than $1,000 for each violation and may order restitution to borrowers and reimbursement of the department's costs in bringing an administrative action. The department may suspend or revoke the right of a person or licensee, directly or through an officer, agent, employee, or representative, to operate as a licensee or to engage in the business of making consumer loans.

(4) The department's remedies specified in this chapter are cumulative.

(5) A revocation or suspension of a license does not relieve the licensee from civil, administrative, or criminal liability for acts committed prior to the revocation or suspension of the license.

(6) All civil penalties collected pursuant to this section must be deposited in the state general fund.

History: En. Sec. 23, Ch. 283, L. 1959; amd. Sec. 116, Ch. 431, L. 1975; R.C.M. 1947, 47-223; amd. Sec. 6, Ch. 372, L. 2007; amd. Sec. 6, Ch. 173, L. 2013; amd. Sec. 5, Ch. 23, L. 2015.

Cross-References

Department — powers and duties, 32-5-401.

32-5-208. Reinstatement. The department may reinstate any revoked license if there is not a fact or condition existing at the time of reinstatement that would have justified the department in refusing originally to issue the license. In any case in which the license has been revoked for cause, an application may not be made for issuance of a new license or the reinstatement of a revoked license for a period of 6 months from the date of revocation.

History: En. Sec. 24, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-224; amd. Sec. 7, Ch. 372, L. 2007.

Cross-References

Department — powers and duties, 32-5-401.

32-5-209. Department authorized to participate in nationwide licensing system for purposes of licensing consumer loan licensees — rulemaking. (1) The department may participate in a nationwide licensing system for licensing purposes under this chapter and may require consumer loan licensees to apply for licensure on applications approved by the nationwide licensing system.

(2) The department may establish rules that are necessary to comply with the nationwide licensing system protocols and procedures pertaining to applications, fees, renewal dates, amending or surrendering a license, and submission of reports necessary for participation in the nationwide licensing system.

(3) The department's portion of the licensing fees collected through the nationwide licensing system must be deposited into the department's account in the state special revenue fund for use in the administration of this part.

History: En. Sec. 13, Ch. 173, L. 2013.

Part 3
Operation of Business — Restrictions and Requirements

32-5-301. Fees charged to consumers. (1) A licensee may contract for and receive interest on the principal amount of any loan. The interest, excluding the fees authorized in subsections (3) and (4), may not exceed 36% a year.

(2) The following third-party fees may be financed at the borrower's option and included in the principal amount of any loan:

(a) the actual fees paid to a public official or agency of the state for filing, recording, or releasing any instrument securing the loan;

(b) the premium for insurance in lieu of filing or recording any instrument securing the loan to the extent that the premium does not exceed the fees that would otherwise be payable for filing, recording, or releasing any instrument securing the loan;

(c) the premium for any credit insurance;

(d) bona fide fees or charges related to real estate security paid to third parties;

(e) fees or premiums for title examination, title insurance, or similar purposes, including survey;

(f) fees for preparation of a deed, settlement statement, or other documents;

(g) fees for notarizing deeds and other documents;

(h) appraisal fees;

(i) fees for credit reports; and

(j) fees paid to a trustee for release of a trust deed.

(3) (a) If provided for in the contract, a licensee may grant a deferral at any time. A deferral postpones the scheduled due date of the earliest unpaid installment and all subsequent installments as originally scheduled or as previously deferred for a period equal to the agreed-upon deferral period. The deferral period is that period during which an installment is not scheduled to be paid by reason of the deferral.

(b) A licensee may charge an additional fee for each deferral. The fee charged may be the greater of $15 or 5% of the amount currently due, not to exceed $50.

(c) Other fees may not be charged by the lender for any deferrals granted by the lender.

(4) If provided for in the contract, a licensee may charge a fee for any amount past due, whether as a result of a default under the original contract terms or of a default under the terms of an extension agreement. The fee charged may be the greater of $15 or 5% of the amount past due, not to exceed $50. The fee charged for any past-due amount may be charged only once. Other fees may not be charged for any default of the contract by the borrower.

(5) At the borrower's option, a licensee may finance and include in the principal amount of any loan a guaranteed asset protection waiver provided under the Guaranteed Asset Protection Waiver Act as provided in Title 30, chapter 14, part 22.

(6) (a) No other fees or charges may be directly or indirectly contracted for or received by any licensee except those specifically authorized by this chapter. A licensee may not divide into separate parts any contract made for the purpose of or with the effect of obtaining fees in excess of those authorized by this chapter. In addition to other remedies and penalties provided for in this chapter, if any amount in excess of the fees permitted by this chapter is charged, contracted for, or received, the licensee shall forfeit to the borrower a sum that is double the amount that is in excess of the fees authorized by this chapter.

(b) This section does not apply to fees for services rendered in connection with a loan after the loan has been consummated and if the borrower's participation in the services is strictly voluntary.

History: Ap. p. Sec. 10, Ch. 283, L. 1959; amd. Sec. 1, Ch. 15, L. 1965; Sec. 47-210, R.C.M. 1947; Ap. p. Sec. 5, Ch. 283, L. 1959; amd. Sec. 3, Ch. 233, L. 1971; amd. Sec. 3, Ch. 172, L. 1975; amd. Sec. 172, Ch. 431, L. 1975; Sec. 47-205, R.C.M. 1947; R.C.M. 1947, 47-205(part), 47-210; amd. Sec. 6, Ch. 216, L. 1979; amd. Sec. 4, Ch. 424, L. 1981; amd. Sec. 2, Ch. 135, L. 1983; amd. Sec. 4, Ch. 140, L. 1983; amd. Sec. 2, Ch. 168, L. 1985; amd. Sec. 3, Ch. 406, L. 1985; amd. Sec. 3, Ch. 198, L. 1993; amd. Sec. 2, Ch. 270, L. 1999; amd. Sec. 1, Ch. 308, L. 2003; amd. Sec. 3, Ch. 125, L. 2005; amd. Sec. 8, Ch. 372, L. 2007; amd. Sec. 8, I.M. No. 164, approved Nov. 2, 2010; amd. Sec. 7, Ch. 173, L. 2013; amd. Sec. 1, Ch. 311, L. 2015.

Cross-References

Legal interest, 31-1-106.
Interest rate allowed by agreement, 31-1-107.
Penalty for usury — action to recover excessive interest, 31-1-108.
Limitation of Rule of 78ths, 31-1-113.
Finance charge limitation, 31-1-241.
License application and fees, 32-5-201.
Penalties, 32-5-406.

32-5-302. Installment and balloon payments. (1) Except as provided in subsection (4), if the loan contract requires installment payments, the contract must provide that principal and interest be payable at approximately equal periodic intervals, except that payment dates may be omitted to accommodate borrowers with seasonal incomes.

(2) An installment contracted for may not be substantially larger than any preceding installment. If a loan contract provides for monthly installment payments, the first installment must be payable at any time within 45 days of the date of the making of the loan.

(3) A licensee may not enter into any loan contract in which a borrower agrees to pay principal or interest in one lump sum unless the payment is due not less than 45 days from the date of the making of the loan and not more than 1 year from the date of the making of the loan.

(4) Loans with a balloon payment are permissible so long as all installment payments cover at least the interest that has accrued since the previous installment payment.

History: En. Sec. 11, Ch. 283, L. 1959; amd. Sec. 4, Ch. 233, L. 1971; amd. Sec. 36, Ch. 71, L. 1977; R.C.M. 1947, 47-211; amd. Sec. 5, Ch. 424, L. 1981; amd. Sec. 1, Ch. 150, L. 1991; amd. Sec. 4, Ch. 198, L. 1993; amd. Sec. 4, Ch. 374, L. 1997; amd. Sec. 9, Ch. 372, L. 2007; amd. Sec. 8, Ch. 173, L. 2013.

Cross-References

Contracts — time of performance, Title 28, ch. 3, part 6.

Montana Retail Installment Sales Act, Title 31, ch. 1, part 2.

32-5-303. Borrower to receive copy of contract or statement of contents. (1) At the time a loan is made, there must be delivered to the borrower or borrowers the disclosures required by the federal Consumer Credit Protection Act and the federal Truth in Lending Act, 15 U.S.C. 1601, et seq., and a copy of the loan contract or a written statement showing in clear and distinct terms:

(a) the name and address of the lender and of one of the borrowers or a maker of the loan;

(b) the date of the loan contract;

(c) the description or schedule of payments;

(d) the principal amount of the loan excluding interest;

(e) the rate and amount of interest as provided in the contract;

(f) the amount collected or paid out for each kind of insurance, if any;

(g) the amount collected or paid out for filing and other fees as allowed in this chapter;

(h) the collateral or security for the loan including all other accommodation or other joint makers or comakers; and

(i) that the borrower may prepay the loan in whole or in part without penalty at any time during a licensee's regular business hours.

(2) Compliance with the disclosure requirements of the Truth in Lending Act, 15 U.S.C. 1601, et seq., does not constitute authorization to enlarge or modify the interest or the fees that may be charged under 32-5-301.

History: En. Sec. 12, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-212(part); amd. Sec. 6, Ch. 424, L. 1981; amd. Sec. 4, Ch. 406, L. 1985; amd. Sec. 10, Ch. 372, L. 2007; amd. Sec. 9, Ch. 173, L. 2013.

Cross-References

Requirements of retail installment contracts, 31-1-231.

32-5-304. Receipts — return of note. Every licensee shall:

(1) give to the borrower a plain, dated, and complete receipt for every payment made in cash on account of any loan at the time the payment is made;

(2) endorse indelibly on a loan ledger or card or maintain a record by reliable electronic means of the amount and date of each payment made by the borrower; and

(3) upon repayment of the loan in full, mark indelibly every obligation and security signed by the borrower with the word "paid" or "canceled" or otherwise memorialize satisfaction of the obligation and release any mortgage, restore any pledge, and cancel and return to the borrower any note and any assignment given to the licensee within 10 days after the repayment. Reconveyance of a deed of trust must be in accordance with 71-1-307 through 71-1-309. The canceled note and canceled assignment or other instrument clearly identifying the note or assignment and stating that it has been paid in full must be mailed to the borrower at the borrower's last-known address unless returned to the borrower in person.

(4) maintain records in accordance with 32-5-307.

History: En. Sec. 12, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-212(part); amd. Sec. 1, Ch. 84, L. 1981; amd. Sec. 1053, Ch. 56, L. 2009; amd. Sec. 10, Ch. 173, L. 2013.

Cross-References
Notice and receipt of payment, 31-1-236.

32-5-305. Confessions of judgment — incomplete instruments forbidden. A licensee may not:

(1) take any confession of judgment from the borrower or any power of attorney running to the licensee or to any third person to confess judgment for the borrower or to appear for the borrower in a judicial proceeding, except that this subsection does not prohibit a borrower from personally and voluntarily confessing judgment after the borrower's loan is in default;

(2) take any note or promise to pay that does not disclose the amount of the loan, a schedule of payments or a description of the schedule of payments, and the agreed interest and fees to be charged. The note or promise may not contain blanks that are left to be filled in after execution. The disclosures required by this subsection are not required on a certificate of title to a motor vehicle, on a policy or certificate of insurance, or on customary powers in connection with bonds or stocks that may be pledged as collateral.

(3) take any instrument in which blanks are left to be filled in after the loan is made.

History: En. Sec. 13, Ch. 283, L. 1959; R.C.M. 1947, 47-213; amd. Sec. 11, Ch. 372, L. 2007; amd. Sec. 11, Ch. 173, L. 2013.

Cross-References
Confession of judgment, Title 27, ch. 9.
Requirements of retail installment contracts, 31-1-231.

32-5-306. Insurance — real property security — definitions. (1) Except as provided in this section, insurance may not be written by a licensee or employee, affiliate, or associate of the licensee in connection with any loan.

(2) Insurance permitted under the provisions of this section must be obtained through an insurance company authorized to conduct business in Montana by a licensed insurance producer or agency of this state. Premiums may not exceed those fixed by law or current applicable manual rates. Insurance written as authorized by this section may contain a mortgagee clause or other appropriate provisions to protect the insurable interest of the licensee.

(3) (a) When the principal amount of the loan exceeds $300 exclusive of the portion of the loan attributable to insurance premiums and fees, the licensee may require a borrower to insure property offered as security against any substantial risk of loss, damage, or destruction for an amount not to exceed the reasonable value of the property insured or the amount of the loan, whichever is smaller, and for the customary term approximating the term of the loan contract. It is optional with the borrower to obtain insurance in an amount greater than the amount of the loan or for a longer term.

(b) A lender may not require a borrower, as a condition of obtaining or maintaining a loan secured by real property, to provide insurance on improvements to real property in an amount that exceeds the reasonable replacement value of the improvements.

(4) Subject to the laws of this state, credit life insurance, credit disability insurance, and loss of income insurance may be provided at the expense of the borrower and may be provided by a licensee upon the request of the borrower when the principal amount of the loan exceeds $300, exclusive of the portion of the loan attributable to insurance premiums and fees.

(5) The insurance authorized by this section may be sold, obtained, or provided by or through a licensee, and the premium or identifiable fee for the insurance may be included in the principal amount of the loan. However, a licensee may not require a borrower to purchase insurance from the licensee or from any particular insurance producer, broker, or insurance company as a condition precedent for obtaining a loan. Any gain or advantage to the licensee or any employee, affiliate, or associate of the licensee from the sale, provision, or obtaining of insurance as authorized by this section may not be considered to be a violation of this chapter.

(6) A licensee may not require insurance under this section until any existing insurance of the same type has expired or has been canceled.

(7) As used in this section:

(a) "borrower" means a mortgagor, grantor of a deed of trust, or other debtor;

(b) "improvement to real property" means a fixture, building, or other structure attached to real property and intended as a permanent addition to the real property; and

(c) "lender" means a mortgagee, beneficiary of a deed of trust, or other creditor who holds a mortgage, deed of trust, or other instrument that encumbers real property as security for the repayment of a debt.

History: En. Sec. 14, Ch. 283, L. 1959; amd. Sec. 2, Ch. 15, L. 1965; amd. Sec. 5, Ch. 233, L. 1971; amd. Sec. 4, Ch. 172, L. 1975; R.C.M. 1947, 47-214; amd. Sec. 4, Ch. 216, L. 1979; amd. Sec. 7, Ch. 424, L. 1981; amd. Sec. 5, Ch. 140, L. 1983; amd. Sec. 1, Ch. 193, L. 1989; amd. Sec. 1, Ch. 97, L. 2005; amd. Sec. 12, Ch. 372, L. 2007.

Cross-References

Retail installment contracts — insurance, 31-1-233.
Insurance, Title 33.
Credit life and disability insurance, Title 33, ch. 21.

32-5-307. Records to be kept. Each licensee shall keep or make available in each licensed office the books, accounts, and records that the department requires and that are necessary to enable the department to determine whether the licensee is complying with this chapter and with the rules promulgated under this chapter. The licensee shall preserve the records for at least 2 years after making the final entry on any loan recorded in the records.

History: En. Sec. 17, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-217; amd. Sec. 5, Ch. 374, L. 1997.

Cross-References

Department — powers and duties — adoption of rules, 32-5-401.
Access to records — witnesses, 32-5-404.

32-5-308. Annual report. (1) A licensee shall file an annual report by the date and in the manner prescribed by the department covering the licensee's consumer loan activity in this state during the preceding calendar year.

(2) The report must contain the information prescribed by the department. The department may require information that is consistent with the protocols of a nationwide licensing system as provided in 32-5-209.

History: En. Sec. 18, Ch. 283, L. 1959; amd. Sec. 115, Ch. 431, L. 1975; R.C.M. 1947, 47-218; amd. Sec. 1, Ch. 64, L. 2005; amd. Sec. 13, Ch. 372, L. 2007; amd. Sec. 5, Ch. 96, L. 2013; amd. Sec. 12, Ch. 173, L. 2013.

Cross-References

Annual examinations — cost, 32-5-403.

32-5-309. Advertising — limitations. No person shall advertise, display, distribute, broadcast, or televise or permit to be displayed, advertised, distributed, broadcasted, or televised, in any manner whatsoever, any false, misleading, or deceptive statement or representation with regard to the rates, terms, or conditions of loans.

History: En. Sec. 19, Ch. 283, L. 1959; R.C.M. 1947, 47-219.

Cross-References

Montana Unfair Trade Practices and Consumer Protection Act of 1973, Title 30, ch. 14, part 1.
When advertising as bank prohibited, 32-1-402.

32-5-310. Wage assignments — limitations. (1) Subject to the limitations in subsection (2), wage assignments, which include salary, wages, commissions, and other compensation for services, are permitted and any loan made subject to a wage assignment must be considered a loan secured by the wage assignment. The amount by which the assignment exceeds the amount of the consideration actually paid, for the purposes of regulation under this chapter, may not be considered interest on the loan and must be credited to the borrower. Transactions subject to the provisions of this section are governed by and are subject to the provisions of this chapter.

(2) Any assignment to a licensee or for the benefit of a licensee of salary, wages, commissions, or other compensation for services may not exceed 10% of the salary, wages, commissions, or other compensation owing at the time of the notice to the debtor's employer or that is subsequently owed. An assignment is not valid unless it is in writing and is signed in person by the borrower or if the borrower is married is signed in person by both husband and wife, provided that written assent of a spouse is not required when husband and wife have been and are living separate and apart when the assignment is made. Notice of the assignment must be given to the debtor's employer only if the debtor defaults in payment of the whole or some part of the loan for which the assignment is security. The notice must be served on the employer or a managing agent of the employer, must be verified by the licensee or the licensee's agent, and must include:

(a) a correct copy of the assignment;

(b) a statement of the amount of the loan and the amount due and unpaid; and

(c) a copy of this section.

(3) The acceptance and honoring of any assignment must be at the option of the employer.

History: En. Sec. 20, Ch. 283, L. 1959; amd. Sec. 37, Ch. 71, L. 1977; R.C.M. 1947, 47-220; amd. Sec. 14, Ch. 372, L. 2007; amd. Sec. 6, Ch. 96, L. 2013.

Cross-References

Wage brokers, Title 31, ch. 1, part 3.

32-5-311. Precomputed interest prohibited. All consumer loans made or refinanced under this chapter must be made on simple interest, and the interest on consumer loans made or refinanced under this chapter may not be precomputed.

History: En. Sec. 14, Ch. 173, L. 2013.

32-5-312 through 32-5-320 reserved.

32-5-321. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 1, Ch. 341, L. 1979.

32-5-322. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 2, Ch. 341, L. 1979; amd. Sec. 3, Ch. 168, L. 1985; amd. Sec. 5, Ch. 406, L. 1985.

32-5-323. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 3, Ch. 341, L. 1979.

32-5-324. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 4, Ch. 341, L. 1979.

Part 4
Enforcement

32-5-401. Department — powers and duties — adoption of rules. (1) All powers and duties of regulation and supervision conferred by this chapter are vested in the department. The department shall adopt rules necessary to carry out the intent and purposes of this chapter.

(2) All rules adopted under this chapter are binding on all persons and enforceable by the department as provided in this chapter.

History: En. Sec. 3, Ch. 283, L. 1959; amd. Sec. 111, Ch. 431, L. 1975; R.C.M. 1947, 47-203; amd. Sec. 15, Ch. 372, L. 2007.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

Notice of violation — administrative hearing — penalties — liability, 32-5-207.

32-5-402. Investigations by department — subpoenas — oaths — examination of witnesses and evidence. (1) The department may at any time investigate any transaction with borrowers and may examine the books, accounts, and records to discover violations of this chapter by:

(a) a licensee; or

(b) a person who the department has reason to believe is violating or is about to violate this chapter.

(2) The department or the department's authorized representatives must be given free access to the offices and places of business and files of all licensees. The department may investigate any matter, upon complaint or otherwise, if it appears that a person has engaged in or offered to engage in any act or practice that is in violation of any provision of this chapter or any rule adopted or order issued by the department pursuant to this chapter.

(3) The department may issue subpoenas to compel the attendance of witnesses and the production of documents, papers, books, records, and other evidence before it in any matter over which it has jurisdiction, control, or supervision pertaining to this chapter. The department may administer oaths and affirmations to a person whose testimony is required.

(4) If a person refuses to obey a subpoena or to give testimony or produce evidence as required by the subpoena, a judge of the district court in the county in which the licensed premises are located or in the district court of Lewis and Clark County if no licensed premises are maintained in the state may, upon application and proof of the refusal, issue a subpoena or subpoena duces tecum for the witness to appear before the department to give testimony

and produce evidence as may be required. The clerk of court shall then issue the subpoena, as directed, under the seal of the court, requiring the person to whom it is directed to appear at the time and place designated in the subpoena.

(5) If a person served with a subpoena refuses to obey the subpoena or to give testimony or produce evidence as required by the subpoena, the department may proceed under the contempt provisions of Title 3, chapter 1, part 5.

(6) Failure to comply with the requirements of a court-ordered subpoena is punishable pursuant to 45-7-309.

History: En. Sec. 15, Ch. 283, L. 1959; amd. Sec. 6, Ch. 233, L. 1971; amd. Sec. 5, Ch. 172, L. 1975; amd. Sec. 114, Ch. 431, L. 1975; R.C.M. 1947, 47-215; amd. Sec. 5, Ch. 216, L. 1979; amd. Sec. 8, Ch. 424, L. 1981; amd. Sec. 6, Ch. 140, L. 1983; amd. Sec. 16, Ch. 372, L. 2007; amd. Sec. 6, Ch. 23, L. 2015; amd. Sec. 14, Ch. 535, L. 2021.

Cross-References

Montana Unfair Trade Practices and Consumer Protection Act of 1973 — investigative authority, 30-14-114.
Records to be kept, 32-5-307.
Advertising — limitations, 32-5-309.

32-5-403. Examinations — cost. (1) The department may examine the books, accounts, and records of every licensee insofar as they relate to transactions with borrowers under this chapter.

(2) The expenses of the department incurred in the examination of the books, accounts, and records of the licensees must be charged at a rate established by the department by rule. The amount charged must be established to recover all of the costs of the department's supervision program. Each licensee must be billed by the department for the amount charged to the licensee pursuant to this section. If the charge is not paid within 30 days after the mailing of the bill, the license of the licensee may be suspended or revoked.

History: En. Sec. 16, Ch. 283, L. 1959; amd. Sec. 7, Ch. 233, L. 1971; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-216; amd. Sec. 1, Ch. 368, L. 1983; amd. Sec. 7, Ch. 600, L. 1985; amd. Sec. 17, Ch. 372, L. 2007.

Cross-References

Banks — examination and supervision by Department, 32-1-211.
Mutual savings and loan associations — examinations and supervision by Department, 32-2-701.
Credits unions — examinations, 32-3-203.
Annual report, 32-5-308.

32-5-404. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 26, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; amd. Sec. 38, Ch. 71, L. 1977; R.C.M. 1947, 47-226.

32-5-405. Injunctions — receivers. (1) Whenever the department has reasonable cause to believe that a person is violating or is threatening to violate any provision of this chapter, the department may, in addition to all actions provided for in this chapter and without prejudice to those actions, bring an action in the name of the state against the person to restrain by temporary or permanent injunction or temporary restraining order the use of the unlawful method, act, or practice.

(2) The notice for an action pursuant to subsection (1) must state generally the relief sought and must be served at least 20 days before the hearing of the action in which the relief sought is a temporary or permanent injunction. The notice for a temporary restraining order is governed by 27-19-315.

(3) An action under this section may be brought in the district court in the county in which a person resides or has the person's principal place of business or in the district court of Lewis and Clark County if the person is not a resident of this state or does not maintain a place of business in this state.

(4) A district court may issue temporary or permanent injunctions or temporary restraining orders to restrain and prevent violations of this chapter, and an injunction must be issued without bond to the department.

(5) In addition to all other means provided by law for the enforcement of a restraining order or injunction, the court in which the action is brought may impound and appoint a receiver for the property and business of the defendant, including books, papers, documents, and records pertaining to the property or business or as much of the property or business as the court considers reasonably necessary to prevent violations of this chapter. The receiver, when

appointed and qualified, has the powers and duties as to custody, collection, administration, winding up, and liquidation of the property and business that are conferred upon the receiver by the court.

History: **En. Sec. 27, Ch. 283, L. 1959; amd. Sec. 172, Ch. 431, L. 1975; R.C.M. 1947, 47-227; amd. Sec. 19, Ch. 372, L. 2007.**

Cross-References

Appointment of receiver, Title 25, ch. 14, part 2.
Injunctions, Title 27, ch. 19.
Receivers, Title 27, ch. 20.

32-5-406. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: **En. Sec. 28, Ch. 283, L. 1959; R.C.M. 1947, 47-228.**

32-5-407. Attorney fees — bad check fee. (1) If provided in the contract, reasonable attorney fees may be awarded to the party in whose favor final judgment is rendered in any action on a contract entered into pursuant to the provisions of this chapter.

(2) In addition to any other fees authorized by this chapter, a licensee may charge a borrower the greater of $25 or the licensee's actual expense for each check, draft, converted check, electronic funds transfer, or other authorization or order for the payment of money received in payment of a loan, that is dishonored for any reason.

History: **En. Sec. 10, Ch. 424, L. 1981; amd. Sec. 4, Ch. 168, L. 1985; amd. Sec. 3, Ch. 270, L. 1999; amd. Sec. 20, Ch. 372, L. 2007; amd. Sec. 7, Ch. 23, L. 2015.**

Cross-References

Contractual right to attorney fees treated as reciprocal, 28-3-704.

32-5-408. Cease and desist orders. (1) If the department determines that a person has engaged in or is about to engage in any act or practice constituting a violation of any provision of this chapter or any rule adopted or order issued by the department pursuant to this chapter, the department may issue an order directing the person to cease and desist from continuing the act or practice after issuance and service of a notice and opportunity for an administrative hearing as provided in 32-5-207. The order may apply only to the alleged act or practice constituting a violation of this chapter.

(2) The department may issue a temporary order pending the hearing that:

(a) remains in effect until 14 days after the hearings examiner issues proposed findings of fact and conclusions of law and a proposed order; or

(b) becomes final if the person to whom notice is issued and served does not request a hearing within 14 days after the date on which the notice was sent by certified mail as provided in 32-5-207.

(3) A violation of an order issued pursuant to this section is subject to the penalty provisions of this chapter.

History: **En. Sec. 18, Ch. 372, L. 2007; amd. Sec. 8, Ch. 23, L. 2015.**

32-5-409. Complaint procedure. (1) The department shall maintain a list of licensees that is available to interested persons and to the general public. The department shall also establish by rule a procedure under which an aggrieved consumer or any member of the public may file a complaint against a licensee or an unlicensed person who violates any provision of this chapter.

(2) The department, after giving reasonable notice, may hold hearings, subject to the contested case provisions of Title 2, chapter 4, part 6, upon the request of a party to the complaint, make findings of fact or conclusions of law, issue cease and desist orders, refer the matter to the appropriate law enforcement agency for prosecution for a violation of this chapter, seek injunctive or other relief in district court, or suspend or revoke a license granted under this chapter.

History: **En. Sec. 21, Ch. 372, L. 2007.**

Part 5
Open-End Loans
(Repealed)

32-5-501. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 1, Ch. 218, L. 1981; amd. Sec. 7, Ch. 140, L. 1983; amd. Sec. 5, Ch. 168, L. 1985; amd. Sec. 6, Ch. 406, L. 1985.

32-5-502. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 2, Ch. 218, L. 1981.

32-5-503. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 3, Ch. 218, L. 1981; amd. Sec. 6, Ch. 374, L. 1997.

32-5-504. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 4, Ch. 218, L. 1981.

32-5-505. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 5, Ch. 218, L. 1981; amd. Sec. 7, Ch. 374, L. 1997.

32-5-506. Repealed. Secs. 22, 24(1), Ch. 372, L. 2007.

History: En. Sec. 6, Ch. 218, L. 1981; amd. Sec. 6, Ch. 168, L. 1985; amd. Sec. 7, Ch. 406, L. 1985; amd. Sec. 4, Ch. 270, L. 1999.

CHAPTER 6
ELECTRONIC FUNDS TRANSFER ACT

Part 1 — General Provisions

32-6-101. Short title.
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32-6-103. Definitions.
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Part 2 — Satellite Terminals (Repealed)

Part 3 — Operation

32-6-301. Records of electronic funds transfers.
32-6-302. Verification of statement — procedure for discrepancies.
32-6-303. Unauthorized transactions — liability.
32-6-304. Repealed.
32-6-305. Repealed.
32-6-306. Personal identification number — restrictions.
32-6-307. Repealed.
32-6-308. Repealed.
32-6-309. Repealed.

Part 4 — Regulation and Enforcement (Repealed)

Part 1
General Provisions

Part Cross-References

Payment of taxes by electronic funds transfer, Title 15, ch. 1, part 8.
Uniform Commercial Code — funds transfers, Title 30, ch. 4A.
U.C.C. — funds transfers — exclusion of consumer transactions governed by federal law, 30-4A-108.
Credit Transactions and Relationships, Title 31.

32-6-101. Short title. This chapter shall be known and may be cited as the "Montana Electronic Funds Transfer Act".

History: En. 5-1701 by Sec. 1, Ch. 503, L. 1977; R.C.M. 1947, 5-1701.

32-6-102. Electronic funds transfer systems — applicability. (1) The legislature has determined that electronic funds transfer systems are technologies offered by all types of financial depository institutions. These technologies provide the consumer with both convenience and efficiency in making financial transactions. Regulation E of the federal Electronic Fund

Transfer Act, 15 U.S.C. 1693, et seq., addresses many of the consumer issues relating to these systems. This chapter applies to financial institutions chartered under the United States Code or Title 32, chapter 1, parts 1 through 5, to the extent that those laws permit.

(2) Financial institutions that are subject to and in compliance with Regulation E of the federal Electronic Fund Transfer Act must be considered to be in compliance with the provisions of this chapter.

History: En. 5-1702 by Sec. 2, Ch. 503, L. 1977; R.C.M. 1947, 5-1702; amd. Sec. 12, Ch. 265, L. 1995; amd. Sec. 141, Ch. 42, L. 1997; amd. Sec. 1, Ch. 77, L. 2005.

Cross-References

U.C.C. — funds transfers — subject matter, 30-4A-102.
National bank powers extended to state banks, 32-1-362.
Consolidation or merger of banks, 32-1-371.
Branch bank prohibited — exceptions, 32-1-372.
Financial institutions — exemption from regulation of escrow business, 32-7-103.

32-6-103. Definitions. As used in this chapter, unless the context otherwise requires, the following definitions apply:

(1) "Customer", in relation to a financial institution, means a holder of a demand or time account or a membership share in the institution or a person who is a borrower or a mortgagor; in relation to a merchant, it means a purchaser of goods or services.

(2) "Department" means the department of administration.

(3) (a) "Electronic funds transfer" means any transfer of funds, other than a transaction originated by check, draft, or similar paper instrument that is initiated through an electronic terminal, telephone, computer, or magnetic tape for the purpose of ordering, instructing, or authorizing a financial institution to debit or credit an account. The term includes but is not limited to point-of-sale transfers, automated teller machine transfers, interactive teller machine transfers, direct deposits or withdrawals of funds, and transfers initiated by telephone. It also includes a transfer resulting from a debit card transaction, including a transaction that does not involve an electronic terminal at the time of the transaction.

(b) The term does not include payments made by check, draft, or similar paper instrument at an electronic terminal.

(4) "Electronic terminal" means an electronic device, other than a telephone operated by a consumer, through which a consumer may initiate an electronic funds transfer. The term includes but is not limited to point-of-sale terminals, automated teller machines, interactive teller machines, and cash dispensing machines.

(5) "Financial institution" means a bank chartered under chapter 1 of this title, a bank chartered under the National Banking Acts in Title 12 of the United States Code, a building and loan association chartered under chapter 2 of this title, a savings and loan association chartered under the Home Owners' Loan Act in Title 12 of the United States Code, a credit union chartered under chapter 3 of this title, or a credit union chartered under the Federal Credit Union Act in Title 12 of the United States Code. For purposes of this chapter only, a consumer loan company licensed under chapter 5 is considered a financial institution.

(6) "Merchant" means a natural person, corporation, partnership, or association engaged in buying and selling goods or services, except that a financial institution is not a merchant.

(7) "Person" means an individual, partnership, corporation, association, or any other business organization.

(8) "Premises" means those locations where, by applicable law, financial institutions are authorized to maintain a principal place of business and other offices for the conduct of their respective businesses.

(9) (a) "Satellite terminal" means any machine or device that is located off the premises of a financial institution and that a financial institution or its customers may use to carry out electronic funds transfers.

(b) The term includes:

(i) an automated teller machine, which means a satellite terminal to make electronic funds transfers, that is located off the premises of financial institutions, operated by customers of financial institutions without assistance, and activated by a unique identification device and personal identification number;

(ii) an interactive teller machine as defined in 32-1-109; and

(iii) a point-of-sale terminal, which means a satellite terminal located on the premises of a merchant, operated by a customer, a merchant, or the merchant's employees solely to debit or credit a customer's deposit or share account in a financial institution and solely to credit or debit the merchant's account commensurately for transactions in goods or services. A point-of-sale terminal need not be activated by a unique personal identification device. A merchant has the option, if the necessary computer capability exists at a reasonable cost, of selling goods or services by point-of-sale terminals with the electronic funds transfer taking effect at the time of the transaction or at a stated time after the transaction.

(c) The definition of satellite terminal does not include and nothing in this chapter may be construed to apply to:

(i) an automated teller machine or interactive teller machine located on the premises of a financial institution;

(ii) an automated clearinghouse or any equivalent system designed to transfer funds between financial institutions; or

(iii) a point-of-sale terminal that is used by a merchant in the merchant's business only and does not provide access to a financial institution.

(10) "Unique identification device" means a magnetic encoded plastic card or equivalent device that contains either a number or a dollar balance, or both, that is unique to a customer and that is issued by a financial institution, merchant, or other person.

History: En. 5-1703 by Sec. 3, Ch. 503, L. 1977; R.C.M. 1947, 5-1703; amd. Sec. 2, Ch. 274, L. 1981; amd. Sec. 1, Ch. 255, L. 1989; amd. Sec. 13, Ch. 265, L. 1995; amd. Sec. 101, Ch. 483, L. 2001; amd. Sec. 29, Ch. 75, L. 2019; amd. Sec. 2, Ch. 120, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 2, Ch. 120, L. 2025. Amendment effective October 1, 2025.

Cross-References

U.C.C. — funds transfers — funds transfer — definitions, 30-4A-104.

32-6-104. Consumer information — charge for use of electronic terminal. (1) A financial institution or its affiliate engaging in electronic funds transfers with its customers shall, prior to authorizing a customer to make electronic funds transfers, provide the customer with an itemized statement clearly setting forth, without limitation:

(a) the specific transactions that may be performed through satellite terminals;

(b) the charges, if any, for individual transactions made through a satellite terminal;

(c) minimum balance requirements, if any;

(d) the liability of the various parties for unauthorized transactions made by electronic funds transfer, with special emphasis upon the liability when the customer makes a personal identification number readily available for discovery in connection with theft or loss of the unique identification device and upon the importance of immediate notification to the institution of theft or loss;

(e) the legal status of receipts issued from a satellite terminal;

(f) the right of the customer to a description of transactions performed by satellite terminal on any periodic statement of account furnished the customer;

(g) the right of the customer to seek correction of an error that the customer believes has been made in the customer's account by electronic funds transfer;

(h) instructions in maintaining customer records and reconciling balances and in the importance of retaining receipts of electronic funds transfers; and

(i) the economic significance of having no "float" time and no stop-payment authority.

(2) The customer shall sign a statement acknowledging acceptance of these terms and conditions and give the statement to the financial institution. A copy of the statement, countersigned by an officer of the financial institution, must be provided to the customer. In addition, the information set forth in subsection (1)(d) must be specifically acknowledged by the customer. The customer shall verify acknowledgment by signing the customer's initials immediately adjacent to the information provided.

(3) (a) The owner of an electronic terminal may impose a surcharge for the use of its electronic terminal. The owner of an electronic terminal that elects to impose a surcharge for the use of its electronic terminal shall clearly advise the user of the electronic terminal, by a conspicuous disclosure on the terminal or through a message displayed on the electronic

terminal screen, of the exact amount of the surcharge. The user must then be provided the option either to cancel the transaction, without incurring the surcharge, or to complete the transaction subject to the surcharge.

(b) An agreement by a financial institution to share or operate electronic terminals may not prohibit, limit, or restrict the right of the financial institution to charge a customer any fees allowed by state or federal law or to require a financial institution to waive any other rights or obligations it has under the laws of this state.

(4) A merchant or person other than a financial institution that issues a unique identification device to its customers for use at a point-of-sale terminal and that provides to the holders of the unique identification device a disclosure that satisfies the initial disclosures of terms and conditions under Regulation E of the federal Electronic Fund Transfer Act is considered to be in compliance with the disclosure requirements of this section.

History: En. 5-1706 by Sec. 6, Ch. 503, L. 1977; R.C.M. 1947, 5-1706; amd. Sec. 2, Ch. 255, L. 1989; amd. Sec. 14, Ch. 265, L. 1995; amd. Sec. 1, Ch. 186, L. 2003.

Cross-References

Montana Unfair Trade Practices and Consumer Protection Act of 1973, Title 30, ch. 14, part 1.
Unauthorized transactions — liability, 32-6-303.

32-6-105. Protection of privacy. (1) No information relating to any transaction by electronic funds transfer, or application therefor, between a financial institution and its customer or prospective customer may be disclosed by the financial institution to any person or government entity without:

(a) the consent of the customer; or

(b) a subpoena issued by a court of record directing the financial institution to disclose such information to the person or government entity.

(2) Compliance with such subpoena relieves a financial institution and its employees of liability to a customer or other person for such disclosure.

(3) This section does not prevent:

(a) the examination of financial institutions by duly authorized regulatory authority or the transfer of information by a financial institution to a clearinghouse which administers transactions between financial institutions; or

(b) the access by a party to a transaction to information relating to a specific transaction.

History: En. 5-1709 by Sec. 9, Ch. 503, L. 1977; R.C.M. 1947, 5-1709; amd. Sec. 1, Ch. 186, L. 1987.

Cross-References

Right of privacy, Art. II, sec. 10, Mont. Const.
Evidence — subpoenas, Title 26, ch. 2, part 1.
U.C.C. — funds transfers — security procedure, 30-4A-201.
Investigative subpoenas, Title 46, ch. 4, part 3.
Criminal subpoenas, Title 46, ch. 15, part 1.

32-6-106. Unauthorized disclosure of electronic funds transfer records. (1) A person commits the offense of unauthorized disclosure of electronic funds transfer records if the person has lawful access to the records by virtue of office or employment and:

(a) permits another, who lacks lawful access to the records, to inspect, copy, or read the records; or

(b) transfers the records to another who lacks lawful access to the records.

(2) A person convicted of the offense of unauthorized disclosure of electronic funds transfer records shall be imprisoned in the state prison for any term not to exceed 1 year, be fined not more than $5,000, or be punished by both imprisonment and fine.

History: En. 5-1710 by Sec. 10, Ch. 503, L. 1977; R.C.M. 1947, 5-1710; amd. Sec. 1054, Ch. 56, L. 2009.

Cross-References

U.C.C. — funds transfers — security procedure, 30-4A-201.
Classification of offenses, 45-1-201.
Misdemeanor defined, 45-2-101.

Part 2
Satellite Terminals
(Repealed)

32-6-201. Repealed. Sec. 16, Ch. 265, L. 1995.

History: En. 5-1704 by Sec. 4, Ch. 503, L. 1977; R.C.M. 1947, 5-1704.

32-6-202. Repealed. Sec. 16, Ch. 265, L. 1995.

History: En. 5-1705 by Sec. 5, Ch. 503, L. 1977; R.C.M. 1947, 5-1705; amd. Sec. 6, Ch. 322, L. 1989.

32-6-203. Repealed. Sec. 16, Ch. 265, L. 1995.

History: En. 5-1707 by Sec. 7, Ch. 503, L. 1977; R.C.M. 1947, 5-1707; amd. Sec. 1, Ch. 205, L. 1983.

32-6-204. Repealed. Sec. 16, Ch. 265, L. 1995.

History: En. 5-1708 by Sec. 8, Ch. 503, L. 1977; R.C.M. 1947, 5-1708; amd. Sec. 2, Ch. 205, L. 1983; amd. Sec. 1, Ch. 238, L. 1985; amd. Sec. 7, Ch. 322, L. 1989.

Part 3
Operation

Part Cross-References

Uniform Commercial Code — funds transfers, Title 30, ch. 4A.
U.C.C. — funds transfers — transfer through funds-transfer system, 30-4A-206.
Financial institution's responsibility to provide notice when funds become available for withdrawal, 32-1-440.

32-6-301. Records of electronic funds transfers. (1) A satellite terminal must be operated to produce a humanly readable record of any transaction and to provide a copy of this record to the person initiating the transaction as soon as the transaction is complete.

(2) The receipt provided to the person initiating an electronic funds transfer is admissible as evidence in any legal proceeding and constitutes prima facie proof of the transaction that it records.

(3) (a) A financial institution shall provide each of its customers using electronic funds transfer services with a periodic account statement containing a brief description of all electronic funds transfers sufficient to enable the customer to identify any transaction and relate the transaction to the receipt provided under subsection (1).

(b) The periodic account statement description of automated teller machine transactions must include a specific geographic location where each transaction occurred.

(c) When a periodic account statement includes both electronic funds transfers and other transactions, all electronic funds transfers must be identified as such and be furnished in compliance with this subsection (3).

History: En. 5-1711 by Sec. 11, Ch. 503, L. 1977; R.C.M. 1947, 5-1711; amd. Sec. 15, Ch. 265, L. 1995.

Cross-References

Reproduction of bank records — admissibility in evidence, 32-1-492.
Admissibility of copies in evidence — exception when original available, 32-1-493.
Protection of privacy, 32-6-105.
Unauthorized disclosure of electronic funds transfer records, 32-6-106.

32-6-302. Verification of statement — procedure for discrepancies. (1) If, upon receipt of a periodic statement of account, a customer of a financial institution believes the statement contains an error with respect to an electronic funds transfer, the customer shall notify the institution within 60 days after the day the institution delivered the statement. In this notification, the customer must be identified and shall set forth the foundation of the customer's belief regarding the error.

(2) Within 10 days after a customer has notified a financial institution of a possible error under subsection (1), the institution shall either:

(a) correct the account in question, giving the customer a description of the correction and if the correction is not in the exact amount of the alleged error, the description must explain the difference; or

(b) after investigating the matter, give the customer an explanation of the reasons the institution believes the statement to be correct. If requested in writing by the customer, a written explanation, documented by the institution's record of the transaction in question, must be furnished to the customer.

(3) A financial institution receiving notice under subsection (1) may not close the account concerning which the dispute exists or restrict transactions in the account affecting the portion not in dispute until it complies with subsection (2). A financial institution that has once complied with subsection (2) with respect to an alleged error is not required to respond under subsection (2) to repeated allegations of the same error.

History: En. 5-1712 by Sec. 12, Ch. 503, L. 1977; R.C.M. 1947, 5-1712; amd. Sec. 1055, Ch. 56, L. 2009.

32-6-303. Unauthorized transactions — liability. (1) A customer whose account is debited by an electronic funds transfer without the customer's authorization is not liable for the amount of the transaction, and the amount must be recredited to the customer's account as provided under 32-6-302 unless:

(a) the financial institution has provided the customer with a unique identification device for initiating electronic funds transfer requests and transactions are made as a result of the theft or loss of that device, in which case the customer is liable for the first $50 of any consequent transactions made prior to the time the financial institution is notified of the loss or theft; or

(b) the financial institution has provided the customer with a unique identification device for initiating, in conjunction with a personal identification number separate from the device, electronic funds transfer requests and the customer attaches the personal identification number to the device by writing or otherwise or in any way makes the number readily available for discovery in connection with the theft or loss of the device and transactions are made as a result of the theft or loss of the device, in which case the customer is liable for one-half the value of all consequent transactions made until the financial institution is notified of the theft or loss.

(2) A customer who willingly gives the customer's unique identification device and personal identification number to another is presumed to have authorized any electronic funds transfers requested by the other person.

(3) A merchant who makes electronic funds transfer services available on the merchant's premises is liable for the amount of an unauthorized electronic funds transfer requested from the premises only if the merchant:

(a) or the merchant's agent is negligent in requiring a user of electronic funds transfer services to furnish adequate self-identification;

(b) fails to retain a physical record of the transaction for 1 year following the transaction; or

(c) breaches the warranty required by subsection (4).

(4) A merchant operating a point-of-sale terminal shall warrant to the financial institution or the department that an order for an electronic funds transfer emanating from the terminal is part of a commercial transaction in which the customer receives goods or services of commensurate value.

(5) The liability for any unauthorized or erroneous electronic funds transfer that does not fall upon a customer or a merchant under this section falls upon the financial institution that carries out the transfer.

History: En. 5-1713 by Sec. 13, Ch. 503, L. 1977; R.C.M. 1947, 5-1713; amd. Sec. 3, Ch. 255, L. 1989; amd. Sec. 1056, Ch. 56, L. 2009.

Cross-References

U.C.C. — funds transfers — unenforceability of certain verified payment orders, 30-4A-203.
U.C.C. — funds transfers — erroneous payment orders, 30-4A-205.
Destruction of bank records, 32-1-491.
Consumer information, 32-6-104.

32-6-304. Repealed. Sec. 17, Ch. 117, L. 1997.

History: En. 5-1714 by Sec. 14, Ch. 503, L. 1977; R.C.M. 1947, 5-1714.

32-6-305. Repealed. Sec. 16, Ch. 265, L. 1995.

History: En. 5-1715 by Sec. 15, Ch. 503, L. 1977; R.C.M. 1947, 5-1715; amd. Sec. 4, Ch. 255, L. 1989.

32-6-306. Personal identification number — restrictions. (1) A financial institution may not assign a personal identification number to a customer which is identical to that customer's social security account number, driver's license number, or any other number assigned for other purposes to that customer.

(2) A satellite terminal may not be operated so as to print a customer's personal identification number on the humanly readable receipt furnished at the time of a transaction.

History: En. 5-1716 by Sec. 16, Ch. 503, L. 1977; R.C.M. 1947, 5-1716.

Cross-References

U.C.C. — funds transfers — security procedure, 30-4A-201.
Personal identification number defined, 32-6-103.
Driver's license, 61-5-111.

32-6-307. Repealed. Sec. 16, Ch. 265, L. 1995.

History: En. 5-1717 by Sec. 17, Ch. 503, L. 1977; R.C.M. 1947, 5-1717.

32-6-308. Repealed. Sec. 16, Ch. 265, L. 1995.
History: En. 5-1718 by Sec. 18, Ch. 503, L. 1977; R.C.M. 1947, 5-1718.

32-6-309. Repealed. Sec. 16, Ch. 265, L. 1995.
History: En. 5-1719 by Sec. 19, Ch. 503, L. 1977; R.C.M. 1947, 5-1719.

Part 4
Regulation and Enforcement
(Repealed)

32-6-401. Repealed. Sec. 17, Ch. 117, L. 1997.
History: En. 5-1720 by Sec. 20, Ch. 503, L. 1977; R.C.M. 1947, 5-1720.

32-6-402. Repealed. Sec. 17, Ch. 117, L. 1997.
History: En. 5-1721 by Sec. 21, Ch. 503, L. 1977; R.C.M. 1947, 5-1721.

CHAPTER 7
ESCROW BUSINESSES

Part 1 — Regulation of Escrow Businesses

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32-7-124. Hearings — penalties.

Part 1
Regulation of Escrow Businesses

32-7-101. Title and purpose. (1) This part must be known and may be cited as the "Regulation of Escrow Businesses Act".

(2) It is the intent of the legislature that the escrow industry be supervised and regulated by the department of administration in order to protect the citizens of the state and to provide that the business practices of the escrow industry are fair and orderly among the members of the escrow industry, with due regard to the ultimate consumers in this important area of property protection.

History: En. Sec. 1, Ch. 651, L. 1989; amd. Sec. 102, Ch. 483, L. 2001.

32-7-102. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Department" means the department of administration as provided for in Title 2, chapter 15, part 10.

(2) "Escrow" means any transaction in which one person, for the purpose of effecting the sale, transfer, encumbrance, or lease of real or personal property to another person or for the purpose of making payments under any encumbrance of the property, delivers any written instrument, money, evidence, title to real or personal property, or other thing of value to a third person to be held by that third person until the happening of a specified event or the performance

of a prescribed condition, when the instrument, money, evidence, title, or thing of value is to be delivered by the third person to a grantee, grantor, promisee, promisor, obligee, obligor, bailee, or bailor or to any agents or employees pursuant to the written escrow instructions.

(3) "Escrow business" means a commercial activity characterized by the regular and continuous carrying on of escrow transactions.

(4) "Licensee" means a person holding a valid license under this part as an escrow business.

(5) "Person" means an individual, cooperative, association, company, firm, partnership, corporation, or other legal entity.

History: En. Sec. 2, Ch. 651, L. 1989; amd. Sec. 103, Ch. 483, L. 2001; amd. Sec. 1, Ch. 216, L. 2013.

32-7-103. Exemptions. (1) The provisions of this part do not apply to the following:

(a) a person licensed by this state pursuant to Title 37, chapter 61, as an attorney at law who is not actively engaged in the escrow business;

(b) a person licensed by this state pursuant to Title 37, chapter 50, as a public accountant who is not actively engaged in the escrow business;

(c) a person whose principal business is that of preparing abstracts or making searches of title that are used as a basis for the issuance of any title insurance policy by a company doing business under the laws of this state relating to insurance companies and the person is regulated by the commissioner of insurance;

(d) a person licensed pursuant to Title 32, chapter 9, part 1, as a mortgage broker, mortgage lender, or mortgage servicer, except that a licensed mortgage broker, mortgage lender, or mortgage servicer that provides escrow services in relation to contracts, agreements, or transactions besides residential mortgage loan agreements also must be licensed under this part as an escrow business;

(e) a financial institution, as defined in 32-6-103, that has its escrow accounts regularly audited or examined. The financial institution shall supply a copy of the most recently prepared audit or examination to the department upon the department's request.

(f) except as provided in subsection (2), any broker licensed by the Montana board of realty regulation if the broker is performing an act in the course of or incidental to a single real estate transaction for which a real estate license is required;

(g) any person furnishing escrow services under the order of a court; and

(h) a loan closer if the loan closer:

(i) is employed by an exempt financial institution; or

(ii) is an independent contractor acting only as a courier and who does not take possession of the funds for deposit or subsequent disbursement.

(2) A trust account of a broker licensed by the Montana board of realty regulation is not an escrow account within the meaning of this part.

History: En. Sec. 3, Ch. 651, L. 1989; amd. Sec. 1057, Ch. 56, L. 2009; amd. Sec. 3, Ch. 317, L. 2011; amd. Sec. 2, Ch. 216, L. 2013.

32-7-104. Exemption or exception — burden of proof. In any proceeding under this part, the burden of proving an exemption or exception from a definition is upon the person claiming it.

History: En. Sec. 4, Ch. 651, L. 1989.

32-7-105 through 32-7-107 reserved.

32-7-108. Department — powers and duties. (1) The department shall exercise general supervision and control over persons doing escrow business in this state.

(2) In addition to the other duties imposed upon the department by law, the department shall:

(a) adopt reasonable rules necessary to effectuate the purposes of this part;

(b) conduct examinations and investigations that may be necessary to determine whether a person has engaged or is about to engage in any act or practice constituting a violation of any provisions of this part;

(c) conduct examinations, investigations, and hearings necessary and proper for the efficient administration of this part; and

(d) establish fees commensurate with the costs of issuing the license and examining an escrow business.

History: **En. Sec. 5, Ch. 651, L. 1989; amd. Sec. 1058, Ch. 56, L. 2009; amd. Sec. 3, Ch. 216, L. 2013.**

Cross-References

Rule defined, 2-4-102.
Adoption and publication of rules, Title 2, ch. 4, part 3.

32-7-109. Application for license — bond — issuance. (1) A person must be licensed pursuant to this part before engaging in an escrow business.

(2) An application for a license must be in the form and submitted in the manner prescribed by the department.

(3) At the time of submitting an application for a license, the applicant shall file with the department a bond in an amount to be set by the department by rule. The bond must be issued by a surety company holding a certificate of authority from the Montana state auditor. The bond must be conditioned on the applicant conducting the escrow business in accordance with the requirements of law. All bonds must be renewed annually.

(4) The department shall grant and issue an escrow business license if:

(a) the department has received the bond and application; and

(b) the applicant has complied with all the application requirements of this part, including any protocols of a nationwide licensing system in which the department participates, and any rules promulgated under this part.

(5) An escrow business shall immediately notify the department of any material change in the information contained in the application.

History: **En. Sec. 6, Ch. 651, L. 1989; amd. Sec. 1, Ch. 65, L. 2003; amd. Sec. 7, Ch. 96, L. 2013; amd. Sec. 4, Ch. 216, L. 2013.**

Cross-References

Contested case as including licensing, 2-4-102.
Contested case procedure, Title 2, ch. 4, part 6.
Licensing to follow contested case procedure, 2-4-631.
Licensure of criminal offenders, Title 37, ch. 1, part 2.
Nondiscrimination in licensing, 49-3-204.

32-7-110. Fees. (1) (a) An applicant for licensure shall pay an initial license fee of $350. The annual license renewal fee is $100. The department may direct that fees charged by the department under this section be remitted to the department through a nationwide licensing system as provided in 32-7-112.

(b) The license year for an escrow business license is January 1 through December 31 and all licenses expire annually on December 31.

(c) A licensee may be charged an examination fee based on the actual costs of the examination.

(2) The department's portion of license fees and all examination fees must be deposited with the state treasurer to the credit of the state special revenue fund for use by the department in its licensure and examination functions under this part.

History: **En. Sec. 11, Ch. 651, L. 1989; amd. Sec. 2, Ch. 65, L. 2003; amd. Sec. 5, Ch. 216, L. 2013.**

Cross-References

Professional and occupational licensing boards to establish fees commensurate with costs, 37-1-134.

32-7-111. Transferability. An escrow business license is not transferable or assignable. The provisions of this section apply to the change of ownership of a legal entity licensed as an escrow business under this part if the change of ownership involves a change of control in the entity. For purposes of this section, "change of control" means the transfer of 25% or more of the ownership interests in the entity.

History: **En. Sec. 7, Ch. 651, L. 1989; amd. Sec. 6, Ch. 216, L. 2013.**

32-7-112. Department authority to utilize nationwide licensing system for licensing escrow businesses. (1) The department may participate in a nationwide licensing system for licensing purposes under this part and may require escrow businesses to apply for licensure, in the manner that the department may direct, on application forms approved by the nationwide licensing system.

(2) The department may establish rules that are necessary to comply with the nationwide licensing system protocols and procedures pertaining to fees, renewal dates, amending or surrendering a license, and any other activity necessary for participation in the nationwide licensing system.

(3) The department's portion of the licensing fees collected by the nationwide licensing system must be deposited into the department's account in the state special revenue fund for use in the administration of this part.

History: **En. Sec. 12, Ch. 216, L. 2013.**

32-7-113 and 32-7-114 reserved.

32-7-115. Maintenance of records. (1) A licensee shall establish and maintain the books, accounts, and records necessary to enable the department at any time to determine whether the escrow transactions performed by the licensee comply with the provisions of this part. The books, accounts, and records must be maintained in accordance with generally accepted accounting principles and good business practice.

(2) A licensee shall establish and maintain the following records concerning general accounts:

(a) a general record reflecting the assets, liabilities, capital, income, and expense of the business, maintained in accordance with generally accepted accounting principles;

(b) a cash receipt and disbursement journal; and

(c) a reconciliation of monthly statements to the general record.

(3) The records referred to in subsections (1) and (2) must be reconciled at least once each month with the bank statements reflecting each escrow account.

(4) A licensee shall preserve for at least 3 years after the close of any escrow:

(a) all bank statements reflecting each escrow account and records of monthly reconciliations of the statements to the general record;

(b) all canceled checks drawn on each escrow account;

(c) any additional records reflecting banking transactions regarding each escrow account, including copies of all receipts for funds transferred from other accounts into each escrow account;

(d) all statements of account;

(e) all escrow instructions and amendments to them; and

(f) all additional records pertinent to each escrow transaction.

(5) A licensee shall file annually with the department by a date set by the department by rule a statement of the licensee's financial condition as of December 31 of the preceding calendar year and its transactions and escrow activities during that preceding calendar year concerning consumers in this state. The financial statement must be reviewed by an independent public accountant every odd-numbered year and must be in a form and contain the information that the department requires.

History: **En. Sec. 8, Ch. 651, L. 1989; amd. Sec. 7, Ch. 216, L. 2013; amd. Sec. 1, Ch. 32, L. 2019.**

32-7-116. Statement of account. A licensee shall provide a full statement of an escrow account established under an escrow agreement within 14 days of a written request made by a party to the escrow agreement. The statement must state:

(1) credits to principal;

(2) interest earned for the period; and

(3) other information requested.

History: **En. Sec. 9, Ch. 651, L. 1989.**

32-7-117. Deposit of funds required — disbursement. (1) All money deposited in an escrow to be delivered upon the close of the escrow or upon any other contingency must be deposited with a financial institution, as defined in 32-6-103, doing business in this state and must be kept separate, distinct, and apart from funds belonging to the escrow business. The funds, when deposited, must be designated as "escrow accounts" or given some other appropriate designation indicating that the funds are not the funds of the escrow business.

(2) A person may not knowingly keep or cause to be kept any funds or money with a financial institution, as defined in 32-6-103, under the heading of "escrow accounts" or any other name designating the funds or money as belonging to the clients of any escrow business, except actual escrow funds deposited with the escrow business.

(3) Escrow funds are not subject to execution or attachment on any claim against the escrow business.

(4) Any interest received on funds deposited with an escrow business in connection with any escrow that is deposited in an authorized depository must be paid over to the depositing party to the escrow account and may not be transferred to an account of the escrow business. This section does not limit or restrain the right of the depositing party to contract with respect to the interest received on the deposits by an independent agreement.

(5) An escrow business may not disburse funds from any escrow account until cash, items, or drafts in an amount sufficient to fund any disbursements from the account have been received and deposited in the account and are available for withdrawal from the account as a matter of right. If sufficient funds are available for withdrawal from the account as a matter of right, required disbursements must be made within 5 business days of the receipt of sufficient funds. For the purposes of this subsection (5), the following definitions apply:

(a) "Available for withdrawal from the account as a matter of right" means that the bank or savings and loan association in which an item has been deposited considers the item available for withdrawal as a matter of right and that a final settlement will occur in writing with respect to that item.

(b) "Item" means any check, including a cashier's check, negotiable order of withdrawal, share draft, traveler's check, or money order.

History: En. Sec. 10, Ch. 651, L. 1989; amd. Sec. 3, Ch. 65, L. 2003.

32-7-118 through 32-7-120 reserved.

32-7-121. Unauthorized business practices — penalty. Unauthorized business practices of escrow businesses include but are not limited to the following:

(1) issuing, circulating, making use of, or publishing, by any means of communication, an advertisement indicating that a person is in the escrow business if that person is not a licensed escrow business;

(2) soliciting or accepting an escrow instruction or amended or supplemental escrow instruction containing any blank to be filled in after the signing or initialing of the escrow instruction or permitting any person to make any addition to, deletion from, or alteration of an escrow instruction or amended or supplemental escrow instruction unless the addition, deletion, or alteration is signed or initialed by the affected party who signed or initialed the escrow instruction or amended or supplemental escrow instruction prior to the addition, deletion, or alteration;

(3) failing to carry out the escrow transactions pursuant to the written escrow instructions unless amended by the written agreement of all parties to the escrow agreement or their assigns;

(4) accepting any escrow transaction that requires or has required the prepayment, deduction, or withholding of any sum to cover payments on the indebtedness or any prior encumbrance if the payments are not due and payable to the mortgagee or obligee at the time the escrow is established. However, payments may be made on property taxes for the current year or for the next annual premium on hazard insurance.

(5) refusing to allow parties to an escrow transaction or designated agents of those parties access to the records of the escrow transaction; and

(6) failing to promptly distribute funds pursuant to escrow instructions.

History: En. Sec. 12, Ch. 651, L. 1989; amd. Sec. 8, Ch. 216, L. 2013.

Cross-References

Unfair trade practices and consumer protection, Title 30, ch. 14.
Criminal responsibility of corporations, 45-2-311.
Accountability for conduct of corporation, 45-2-312.

32-7-122. Investigations by department — desist order — injunctions or other actions. (1) The department may investigate, upon complaint or otherwise, if it appears that:

(a) an escrow business is conducting its business in an unsafe and injurious manner or in violation of this part or any rule promulgated pursuant to this part; or

(b) a person is engaging in the escrow business without being licensed under the provisions of this part.

(2) (a) If it appears to the department, upon sufficient grounds or evidence satisfactory to the department, that an escrow business has engaged in or is about to engage in unlicensed activity or any act or practice in violation of this part or any rule or order issued pursuant to this part or that the assets or capital of any escrow business or company are impaired or the

licensee's affairs are in an unsafe condition, the department may summarily order the escrow business to cease and desist from the act or practice or the department may apply to the district court of Lewis and Clark County to enjoin the act or practice and to enforce compliance with this part or for any other appropriate equitable relief.

(b) Upon a proper showing, the court may:

(i) grant a temporary restraining order, followed by a preliminary injunction and a permanent injunction;

(ii) appoint a receiver for the defendant or defendant's assets;

(iii) cancel the licensee's license; and

(iv) order other equitable remedies the court considers necessary and appropriate.

(3) The court may not require the department to post a bond.

History: **En. Sec. 13, Ch. 651, L. 1989; amd. Sec. 9, Ch. 216, L. 2013.**

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.
Public records, Title 2, ch. 6.
Contempts, Title 3, ch. 1, part 5.
Injunctions, Title 27, ch. 19.

32-7-123. Subpoenas — oaths — examinations of witness and evidence. (1) In the conduct of any examination, investigation, or hearing, the department may:

(a) compel the attendance of any person or obtain any documents by subpoena;

(b) administer oaths;

(c) examine any person under oath concerning the business and conduct of affairs of any person subject to the provisions of this part; and

(d) require the production of any books, records, or papers relevant to the inquiry.

(2) If a person refuses to obey a subpoena issued to the department, the district court of Lewis and Clark County or other district court having proper venue, upon application by the department, may order the person to produce documentary evidence or to give evidence relating to the matter under investigation or in question. If a person fails to obey the order of the court, the person may be punished by the court as contempt of court.

History: **En. Sec. 14, Ch. 651, L. 1989; amd. Sec. 10, Ch. 216, L. 2013.**

32-7-124. Hearings — penalties. (1) The department may impose a civil penalty not to exceed $1,000 for each violation if the department finds, after providing a 14-day written notice of alleged violations and opportunity for administrative hearing, that any person, any licensee, or any officer, agent, employee, or representative of the person or licensee, whether licensed or unlicensed, has:

(a) violated any of the provisions of this part;

(b) failed to comply with the rules or orders promulgated by the department;

(c) failed or refused to make required reports to the department;

(d) furnished false information to the department; or

(e) operated without a required license.

(2) The department may issue an order requiring restitution to parties and reimbursement of the department's costs of bringing an administrative action. In addition, the department may issue an order revoking, conditioning, or suspending the right of the licensee, directly or through another, to engage in escrow business activities in this state.

(3) All hearing schedules and orders must be mailed to the person or licensee by certified mail to the address for which the license was issued or, in the case of an unlicensed business, to the last-known address of record.

(4) For purposes of this part, the department is considered to have complied with the requirements of law concerning service of process by sending by common courier with tracking capability any notice required under this part, postage prepaid and addressed to:

(a) the last-known address of the licensee's registered agent for service of process on file with the department;

(b) the last-known address of the licensee on file with the department for an in-state licensee; or

(c) the last-known address of an unlicensed person.

(5) In a judicial action, suit, or proceeding arising under this part or any administrative rule adopted pursuant to this part between the department and a licensee who does not maintain a physical office in this state, venue is in the district court of Lewis and Clark County.

(6) The provisions of the Montana Administrative Procedure Act, Title 2, chapter 4, part 6, apply to a contested case brought under this part.

History: En. Sec. 15, Ch. 651, L. 1989; amd. Sec. 11, Ch. 216, L. 2013; amd. Sec. 2, Ch. 32, L. 2019.

CHAPTER 8
MONTANA FOREIGN CAPITAL DEPOSITORY ACT
(Repealed)

Part 1 — General Provisions — Definitions (Repealed)

Part 2 — Charter — Application — Fee (Repealed)

Part 3 — Regulation and Supervision — Depository Account and Services (Repealed)

Part 4 — Precious Metals Accounts (Repealed)

Part 5 — Financial Privacy (Repealed)

Part 6 — Injunctions — Penalties (Repealed)

Part 1
General Provisions — Definitions
(Repealed)

32-8-101. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 2, Ch. 382, L. 1997.

32-8-102. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 1, Ch. 382, L. 1997.

32-8-103. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 3, Ch. 382, L. 1997; amd. Sec. 104, Ch. 483, L. 2001.

32-8-104. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 4, Ch. 382, L. 1997.

32-8-105. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 5, Ch. 382, L. 1997.

32-8-106. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 6, Ch. 382, L. 1997.

32-8-107. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 7, Ch. 382, L. 1997.

Part 2
Charter — Application — Fee
(Repealed)

32-8-201. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 8, Ch. 382, L. 1997.

32-8-202. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 9, Ch. 382, L. 1997.

32-8-203. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 10, Ch. 382, L. 1997.

32-8-204. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 11, Ch. 382, L. 1997.

32-8-205. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 12, Ch. 382, L. 1997.

Part 3
Regulation and Supervision — Depository Account and Services (Repealed)

32-8-301. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 13, Ch. 382, L. 1997.

32-8-302. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 14, Ch. 382, L. 1997.

32-8-303. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 15, Ch. 382, L. 1997.

32-8-304. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 16, Ch. 382, L. 1997.

32-8-305 reserved.

32-8-306. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 17, Ch. 382, L. 1997.

32-8-307 reserved.

32-8-308. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 18, Ch. 382, L. 1997.

32-8-309. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 19, Ch. 382, L. 1997.

32-8-310 reserved.

32-8-311. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 20, Ch. 382, L. 1997.

32-8-312. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 21, Ch. 382, L. 1997.

32-8-313 reserved.

32-8-314. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 22, Ch. 382, L. 1997; amd. Sec. 68, Ch. 51, L. 1999.

32-8-315. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 23, Ch. 382, L. 1997.

32-8-316. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 24, Ch. 382, L. 1997.

Part 4
Precious Metals Accounts (Repealed)

32-8-401. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 25, Ch. 382, L. 1997.

32-8-402. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 26, Ch. 382, L. 1997.

32-8-403. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 27, Ch. 382, L. 1997; amd. Sec. 69, Ch. 51, L. 1999.

32-8-404. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 28, Ch. 382, L. 1997.

Part 5
Financial Privacy
(Repealed)

32-8-501. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 29, Ch. 382, L. 1997.

32-8-502. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 30, Ch. 382, L. 1997.

32-8-503. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 31, Ch. 382, L. 1997.

32-8-504. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 32, Ch. 382, L. 1997.

32-8-505. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 33, Ch. 382, L. 1997.

32-8-506. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 34, Ch. 382, L. 1997.

32-8-507. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 35, Ch. 382, L. 1997.

32-8-508. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 36, Ch. 382, L. 1997.

32-8-509. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 37, Ch. 382, L. 1997.

32-8-510. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 38, Ch. 382, L. 1997.

32-8-511 through 32-8-514 reserved.

32-8-515. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 39, Ch. 382, L. 1997.

32-8-516. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 40, Ch. 382, L. 1997.

32-8-517. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 41, Ch. 382, L. 1997.

32-8-518. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 42, Ch. 382, L. 1997.

32-8-519 and 32-8-520 reserved.

32-8-521. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 43, Ch. 382, L. 1997.

32-8-522. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 44, Ch. 382, L. 1997.

32-8-523. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 45, Ch. 382, L. 1997.

32-8-524. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 46, Ch. 382, L. 1997.

Part 6
Injunctions — Penalties
(Repealed)

32-8-601. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 65, Ch. 382, L. 1997.

32-8-602. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 66, Ch. 382, L. 1997.

32-8-603. Repealed. Sec. 23, Ch. 163, L. 2005.
History: En. Sec. 67, Ch. 382, L. 1997.

CHAPTER 9
RESIDENTIAL MORTGAGE BROKERS, LENDERS, SERVICERS, AND LOAN ORIGINATORS

Part 1 — Montana Mortgage Act

32-9-101. Short title and purpose.
32-9-102. License requirement — registration.
32-9-103. Definitions.
32-9-104. Exemptions — proof of exemption.
32-9-105. Nationwide mortgage licensing system for mortgage brokers, mortgage lenders, mortgage servicers, and mortgage loan originators.
32-9-106. Simultaneous licensure.
32-9-107. Prelicensing education requirements for mortgage loan originators.
32-9-108. Repealed.
32-9-109. Experience requirements.
32-9-110. Examination requirements for mortgage loan originators.
32-9-111. Repealed.
32-9-112. Application for mortgage broker, mortgage lender, mortgage servicer, and mortgage loan originator license — renewals.
32-9-113. Control persons — application for license — renewal.
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32-9-115. Repealed.
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32-9-117. Fees — disposition of fees — rulemaking.
32-9-118. Continuing education requirements for mortgage loan originators.
32-9-119. Repealed.
32-9-120. Denial of mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator license application or license renewal.
32-9-121. Records maintenance.
32-9-122. Designated manager and branch office license requirements.
32-9-123. Surety bond requirement — notice of legal action.
32-9-124. Prohibitions — required disclosure.
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32-9-133. Penalties — restitution.
32-9-134. License renewal — rulemaking.
32-9-135. Independent contractor entity — responsible individual — loan processor or underwriter.
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32-9-141. Investigations by department — subpoenas — oaths — examination of witnesses and evidence.
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32-9-151. Mortgage call reports.
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32-9-155. Nationwide mortgage licensing system information challenge process.
32-9-156 through 32-9-159 reserved.
32-9-160. Confidentiality.
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32-9-166. Reports.
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32-9-168. Mortgage lender prohibitions.
32-9-169. Mortgage servicer prohibitions.
32-9-170. Mortgage servicer duties.
32-9-171. Repealed.
32-9-172. Mortgage lender net worth requirement.
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32-9-209. Rulemaking.

Part 1
Montana Mortgage Act

Part Compiler's Comments

Contingent Suspension: Section 37, Chapter 321, Laws of 2009, provided: "If the secretary of housing and urban development determines by guideline, interpretation, or rule that any part of [this act] [amending or enacting 32-9-101, 32-9-102, 32-9-103, 32-9-104, 32-9-105, 32-9-106, 32-9-107, 32-9-109, 32-9-110, 32-9-112, 32-9-113, 32-9-114 (repealed), 32-9-116, 32-9-117, 32-9-118, 32-9-120, 32-9-121, 32-9-122, 32-9-123, 32-9-124, 32-9-125 (repealed), 32-9-126, 32-9-127 (repealed), 32-9-128, 32-9-129, 32-9-130, 32-9-133, 32-9-145, 32-9-148, 32-9-150, 32-9-151, 32-9-155, and 32-9-160] is out of compliance with the Secure and Fair Enforcement for Mortgage Licensing Act, Public Law 110-289, the operation and effect of that part is suspended." Section 32, Ch. 125, L. 2013, amended sec. 37, Ch. 321, L. 2009, to provide that the director of the consumer financial protection bureau rather than the secretary of housing and urban development shall make the determination.

32-9-101. Short title and purpose. (1) This part may be cited as the "Montana Mortgage Act".

(2) The legislature recognizes that buying or financing a home is one of the largest, most complicated, and vitally important decisions facing consumers in Montana. Therefore, the legislature finds it desirable to license certain persons in the residential mortgage industry that are outside of the traditional banking industry and that have a direct involvement in consumers' financial welfare, including mortgage brokers, mortgage lenders, mortgage servicers, and mortgage loan originators, to promote honesty, education, and professionalism, to ensure the availability and diversity of residential mortgage funding, and to protect Montana consumers and the stability of Montana's economy.

(3) The legislature finds that it is necessary to implement the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 and, together with the residential mortgage industry, recognizes the importance of statewide participation in the NMLS. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 1, Ch. 516, L. 2003; amd. Sec. 1, Ch. 321, L. 2009; amd. Sec. 4, Ch. 317, L. 2011; amd. Sec. 1, Ch. 125, L. 2013.

32-9-102. License requirement — registration. (1) Unless exempt under 32-9-104, a person may not regularly engage in the business of a mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator with respect to any residential mortgage loan unless licensed or registered under the provisions of this part through the NMLS.

(2) A mortgage broker or mortgage lender may not employ or contract with any person required to be licensed under this part if the person is not licensed. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 2, Ch. 516, L. 2003; amd. Sec. 1, Ch. 301, L. 2005; amd. Sec. 2, Ch. 321, L. 2009; amd. Sec. 5, Ch. 317, L. 2011; amd. Sec. 2, Ch. 125, L. 2013; amd. Sec. 1, Ch. 24, L. 2015.

32-9-103. Definitions. As used in this part, the following definitions apply:

(1) "Administrative or clerical tasks" mean the receipt, collection, and distribution of information common for the processing or underwriting of a loan in the mortgage industry, without performing any analysis of the information, and communication with a consumer to obtain information necessary for the processing or underwriting of a residential mortgage loan.

(2) "Advertising" means a commercial message in any medium, including social media and software, that promotes, either directly or indirectly, a residential mortgage loan transaction.

(3) "Application" means a request, in any form, for an offer of residential mortgage loan terms or a response to a solicitation of an offer of residential mortgage loan terms and includes the information about the borrower that is customary or necessary in a decision on whether to make such an offer.

(4) "Approved education course" means any course approved by the NMLS.

(5) "Approved test provider" means any test provider approved by the NMLS.

(6) "Bona fide not-for-profit entity" means an entity that:

(a) maintains tax-exempt status under section 501(c)(3) or 501(c)(4) of the Internal Revenue Code, 26 U.S.C. 501(c)(3) or 501(c)(4);

(b) promotes affordable housing or provides homeownership education or similar services;

(c) conducts its activities in a manner that serves public or charitable purposes, rather than commercial purposes;

(d) receives funding and revenue and charges fees in a manner that does not create incentives for the entity or its employees to act other than in the best interests of its clients;

(e) compensates employees in a manner that does not create incentives for employees to act other than in the best interests of clients;

(f) provides to or identifies for the borrower residential mortgage loans with terms that are favorable to the borrower and comparable to mortgage loans and housing assistance provided under government housing assistance programs. For purposes of this subsection (6)(f), for residential mortgage loans to have terms that are favorable to the borrower, the department shall determine that the terms are consistent with loan origination in a public or charitable context, rather than a commercial context.

(g) is either certified by the U.S. department of housing and urban development or has received a community housing development organization designation as defined in 24 CFR 92.2.

(7) "Bona fide third party" means a person that provides services relative to the origination of a residential mortgage loan. The term includes but is not limited to real estate appraisers and credit reporting agencies.

(8) "Borrower" means a person seeking a residential mortgage loan or an obligor on a residential mortgage loan.

(9) (a) "Branch office" means a location at which a licensee conducts business other than a licensee's principal place of business.

(b) The location is considered a branch office if:

(i) the address of the location appears on business cards, stationery, or advertising used by the entity;

(ii) the entity's name or advertising suggests that mortgages are made at the location;

(iii) the location is held out to the public as a licensee's place of business due to the actions of an employee or independent contractor of the entity; or

(iv) the location is controlled directly or indirectly by the entity.

(c) A mortgage loan originator working from a remote location is not a branch office if the requirements of 32-9-122 and 32-9-173 are fully met.

(10) (a) "Clerical or support duties" includes:

(i) the receipt, collection, distribution, and analysis of information common for the processing or underwriting of a residential mortgage loan; and

(ii) communicating with a consumer to obtain the information necessary for the processing or underwriting of a residential mortgage loan to the extent that the communication does not include offering or negotiating loan rates or terms or counseling consumers about residential mortgage loan rates or terms.

(b) The term does not include:

(i) taking a residential mortgage loan application; or

(ii) offering or negotiating the terms of a residential mortgage loan.

(11) "Commercial context" means that an individual who acts as a mortgage loan originator does so for the purpose of obtaining profit for an entity or individual for which the individual acts, including a sole proprietorship or other entity that includes only the individual, rather than exclusively for public, charitable, or family purposes.

(12) "Confidential supervisory information" means:

(a) reports of examination, inspection, and visitation; nonpublic operating, condition, and compliance reports; supervisory letters; or similar documents, and any information contained in, derived from, used to create, or related to the documents;

(b) any documents, materials, or records, including reports of examination, prepared by, or on behalf of, or for the use of the department or any state or federal financial services regulatory agency in the exercise of supervisory authority over a supervised entity, and any information derived from or used to prepare the documents, materials, or records;

(c) any communications between the department and a supervised entity or a state or federal financial services regulatory agency related to the department's supervision of the entity;

(d) any information received or generated by the department pursuant to 32-9-130;

(e) confidential criminal justice information, as defined in 44-5-103;

(f) personal information protected by an individual privacy interest; and

(g) information that is exempt from disclosure pursuant to 12 U.S.C. 5111.

(13) (a) "Control" means the power, directly or indirectly, to direct the management or policies of an entity, whether through ownership of securities, by contract, or otherwise.

(b) A person is presumed to control an entity if that person:

(i) is a director, general partner, or executive officer or is an individual that occupies a similar position or performs a similar function;

(ii) directly or indirectly has the right to vote 10% or more of a class of a voting security or has the power to sell or direct the sale of 10% or more of a class of voting securities;

(iii) in the case of a limited liability company, is a managing member; or

(iv) in the case of a partnership, has the right to receive upon dissolution or has contributed 10% or more of the capital.

(14) "Department" means the department of administration provided for in 2-15-1001, acting through its division of banking and financial institutions.

(15) "Depository institution" has the meaning provided in section 3 of the Federal Deposit Insurance Act, 12 U.S.C. 1813(c), and includes any credit union.

(16) "Designated manager" means a mortgage loan originator with at least 3 years of experience as a mortgage loan originator or registered mortgage loan originator who is designated by an entity as the individual responsible for the operation of a particular location that is under the designated manager's full management, supervision, and control.

(17) "Dwelling" has the meaning provided in 15 U.S.C. 1602(w).

(18) "Entity" means a business organization, including a sole proprietorship.

(19) "Escrow account" means a depository account with a financial institution that provides deposit insurance and that is separate and distinct from any personal, business, or other account of the mortgage lender or mortgage servicer and is maintained solely for the holding and payment of escrow funds.

(20) "Escrow funds" means funds entrusted to a mortgage lender or mortgage servicer by a borrower for payment of taxes, insurance, or other payments to be made in connection with the servicing of a loan.

(21) "Expungement" means a court-ordered process that involves the destruction of documentation related to past arrests and convictions.

(22) "Federal banking agency" means the board of governors of the federal reserve system, the comptroller of the currency, the national credit union administration, or the federal deposit insurance corporation.

(23) "Housing finance agency" includes the Montana board of housing provided for in 2-15-1814.

(24) "Independent contractor" means an individual who performs duties other than at the direction of and subject to the supervision and instruction of another individual who is licensed and registered in accordance with this part or who is not required to be licensed in accordance with 32-9-104(1)(b), (1)(d), or (1)(g).

(25) "Independent contractor entity" means an entity that offers or provides clerical or support duties for another person.

(26) "Individual" means a natural person.

(27) "Licensee" means a person authorized pursuant to this part to engage in activities regulated by this part. The term does not include an individual who is a registered mortgage loan originator.

(28) "Loan commitment" means a statement transmitted in writing or electronically by a mortgage lender setting forth the terms and conditions upon which the mortgage lender is willing to make a particular residential mortgage loan to a particular borrower.

(29) (a) "Loan processor or underwriter" means an individual who, with respect to the origination of a residential mortgage loan, performs clerical or support duties as an employee at the direction of and subject to the supervision of a licensed mortgage loan originator or registered mortgage loan originator.

(b) For the purposes of subsection (29)(a), "origination of a residential mortgage loan" means all activities related to a residential mortgage loan from the taking of a residential mortgage loan application through the completion of all required loan closing documents and funding of the residential mortgage loan.

(30) "Mortgage" means a consensual interest in real property located in Montana, including improvements, securing a debt evidenced by a mortgage, trust indenture, deed of trust, or other lien on real property.

(31) (a) "Mortgage broker" means an entity that obtains, attempts to obtain, or assists in obtaining a mortgage loan for a borrower from a mortgage lender in return for consideration or in anticipation of consideration or holds itself out as being able to assist a person in obtaining a mortgage loan.

(b) For purposes of this subsection (31), attempting to obtain or assisting in obtaining a mortgage loan includes referring a borrower to a mortgage lender or mortgage broker, soliciting or offering to solicit a mortgage loan on behalf of a borrower, or negotiating or offering to negotiate the terms or conditions of a mortgage loan with a mortgage lender on behalf of a borrower.

(32) "Mortgage lender" means an entity that closes a residential mortgage loan, advances funds, offers to advance funds, commits to advancing funds for a mortgage loan applicant, or holds itself out as being able to perform any of those functions.

(33) (a) "Mortgage loan originator" means an individual who for compensation or gain or in the expectation of compensation or gain:

(i) takes a residential mortgage loan application; or

(ii) offers or negotiates terms of a residential mortgage loan.

(b) The term includes an individual who represents to the public that the individual can or will perform the services described in subsection (33)(a).

(c) The term does not include an individual:

(i) engaged solely as a loan processor or underwriter, except as provided in 32-9-135; or

(ii) involved solely in extensions of credit relating to timeshare plans, as that term is defined in 11 U.S.C. 101(53D).

(34) "Mortgage servicer" means an entity that:

(a) for forward mortgages:

(i) engages, for compensation or gain from another or on its own behalf, in the business of receiving any scheduled periodic payment from a borrower pursuant to the terms of a residential mortgage loan, residential mortgage servicing documents, or a residential mortgage servicing contract;

(ii) meets the definition of servicer in 12 U.S.C. 2605(i)(2) with respect to residential mortgage loans; or

(iii) holds out to the public that the entity is able to comply with subsection (34)(a)(i) or (34)(a)(ii);

(b) for a home equity conversion mortgage or a reverse mortgage, makes or holds out to the public that the entity can make a payment to the borrower.

(35) "Nationwide mortgage licensing system and registry" or "NMLS" means a licensing system developed and maintained by the conference of state bank supervisors and the American association of residential mortgage regulators for the registration and licensing of persons providing nondepository financial services.

(36) "Nontraditional mortgage product" means any mortgage product other than a 30-year, fixed-rate mortgage.

(37) "Person" means an individual, sole proprietorship, corporation, company, limited liability company, partnership, limited liability partnership, trust, or association.

(38) "Real estate brokerage activities" means activities that involve offering or providing real estate brokerage services to the public, including:

(a) acting as a real estate salesperson or real estate broker for a buyer, seller, lessor, or lessee of real property;

(b) bringing together parties interested in the sale, purchase, lease, rental, or exchange of real property;

(c) negotiating, on behalf of any party, any portion of a contract relating to the sale, purchase, lease, rental, or exchange of real property other than in connection with providing financing with respect to the transaction;

(d) engaging in any activity for which a person is required to be licensed as a real estate salesperson or real estate broker under Montana law; or

(e) offering to engage in any activity or act in any capacity described in subsections (38)(a) through (38)(d).

(39) "Registered mortgage loan originator" means an individual who:

(a) meets the definition of mortgage loan originator and is an employee of:

(i) a depository institution;

(ii) a subsidiary that is wholly owned and controlled by a depository institution and regulated by a federal banking agency; or

(iii) an institution regulated by the farm credit administration; and

(b) is registered with and maintains a unique identifier through the NMLS.

(40) "Regularly engage" means that a person:

(a) has engaged in the business of a mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator on more than five residential mortgage loans in the previous calendar year or expects to engage in the business of a mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator on more than five residential mortgage loans in the current calendar year; or

(b) has served as the prospective source of financing or performed other phases of loan originations on more than five residential mortgage loans in the previous calendar year or expects to serve as the prospective source of financing or perform some other phases of loan origination on more than five residential mortgage loans in the current calendar year.

(41) "Residential mortgage loan" means a loan primarily for personal, family, or household use secured by a mortgage, deed of trust, or other equivalent consensual security interest on a dwelling or on residential real estate located in Montana.

(42) "Residential real estate" means any real property located in the state of Montana upon which is constructed a dwelling or upon which a dwelling is intended to be built within a 2-year period, subject to 24 CFR 3500.5(b)(4). The borrower's intent to construct a dwelling is presumed unless the borrower has submitted a written, signed statement to the contrary.

(43) "Responsible individual" means a Montana-licensed mortgage loan originator with at least 1½ years of experience as a mortgage loan originator or registered mortgage loan originator who is designated by an independent contractor entity as the individual responsible for the operation of a particular location that is under the responsible individual's full management, supervision, and control.

(44) (a) "Service provider" means a person who performs activities relating to the business of mortgage origination, lending, or servicing on behalf of a licensee.

(b) Activities relating to the business of mortgage origination, lending, or servicing include:

(i) providing data processing services;

(ii) performing activities in the support of residential mortgage origination, lending, or servicing; and

(iii) providing internet-related services, including web services, processing electronic borrower payments, developing and maintaining mobile applications, system and software development and maintenance, and security monitoring.

(c) Activities relating to the business of mortgage origination, lending, or servicing do not include providing an interactive computer service or a general audience internet or communications platform, except to the extent that the service or platform is specially designed or adapted for the business of mortgage origination, lending, or servicing.

(d) Activities relating to the business of mortgage origination, lending, or servicing performed by a mortgage loan originator, lender, or servicer on its own behalf or as part of mortgage loan originating, lending, or servicing are considered mortgage loan originating, lending, or servicing.

(45) "Ultimate equity owner" means an individual who, directly or indirectly, owns or controls an ownership interest in a corporation, a foreign corporation, an alien business organization, or any other form of business organization, regardless of whether the individual owns or controls an ownership interest, individually or in any combination, through one or more persons or one or more proxies, powers of attorney, nominees, corporations, associations, partnerships, trusts, joint-stock companies, or other entities or devices.

(46) "Unique identifier" means a number or other identifier assigned by protocols established by the NMLS. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 3, Ch. 516, L. 2003; amd. Sec. 1, Ch. 136, L. 2005; amd. Sec. 1, Ch. 498, L. 2007; amd. Sec. 3, Ch. 321, L. 2009; amd. Sec. 21, Ch. 19, L. 2011; amd. Sec. 6, Ch. 317, L. 2011; amd. Sec. 19, Ch. 123, L. 2013; amd. Sec. 3, Ch. 125, L. 2013; amd. Sec. 2, Ch. 24, L. 2015; amd. Sec. 3, Ch. 65, L. 2019; amd. Sec. 8, Ch. 4, L. 2023.

32-9-104. Exemptions — proof of exemption. (1) The provisions of this part do not apply to:

(a) an entity that is an agency of the federal, state, tribal, or local government;

(b) an individual who is an employee of a federal, state, tribal, local government, or housing finance agency acting as a loan originator only pursuant to the individual's official duties as an employee of the federal, state, tribal, local government, or housing finance agency;

(c) an entity described in 32-9-103(39)(a)(i) through (39)(a)(iii);

(d) a registered mortgage loan originator when acting for an entity described in 32-9-103(39)(a)(i) through (39)(a)(iii);

(e) an individual who performs only administrative or clerical tasks at the direction of and subject to the supervision and instruction of an individual who:

(i) is a licensed and registered mortgage loan originator pursuant to this part; or

(ii) is not required to be licensed in accordance with subsection (1)(b), (1)(d), or (1)(g);

(f) an entity that is a bona fide not-for-profit entity;

(g) an employee of a bona fide not-for-profit entity who acts as a loan originator only with respect to work duties for the bona fide not-for-profit entity and who acts as a loan originator only with respect to residential mortgage loans with terms that are favorable to the borrower, or acts as a servicer with respect to work duties for the bona fide not-for-profit entity;

(h) a person that performs only real estate brokerage activities and is licensed or registered pursuant to 37-51-301 unless the person is compensated by a mortgage broker, a mortgage lender, or a mortgage loan originator or an agent of the mortgage broker, mortgage lender, or mortgage loan originator;

(i) a person regulated by the commissioner of insurance if that person's principal business is that of preparing abstracts or making searches of titles that are used as a basis for the issuance of any title insurance policy by a company doing business under the laws of this state relating to insurance companies;

(j) a Montana-licensed attorney performing activities that fall within the definition of a mortgage loan originator if the activities are:

(i) considered by the Montana supreme court to be part of the authorized practice of law within this state;

(ii) carried out within an attorney-client relationship; and

(iii) accomplished by the attorney in compliance with all applicable laws, rules, and standards; or

(k) an individual who is an employee of a retailer of manufactured or modular homes if the employee is performing only administrative or clerical tasks in connection with the sale or lease of a manufactured or modular home and if the individual receives no compensation or other gain from a mortgage lender or a mortgage broker for the performance of the administrative or clerical tasks.

(2) (a) To qualify for an exemption under subsection (1)(f), an entity shall certify, on a form prescribed by the department, that it is a bona fide not-for-profit entity and shall provide additional documentation as required by the department by rule. To maintain this exemption, the entity shall file the prescribed certification and accompanying documentation by December 31 of each year.

(b) In determining whether an entity is a bona fide not-for-profit entity, the department may rely on its receipt and review of:

(i) reports filed with federal, state, tribal, local government, or housing finance agencies and authorities; or

(ii) reports and attestations prescribed by the department.

(3) The burden of proving an exemption under this section is on the person claiming the exemption. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 4, Ch. 516, L. 2003; amd. Sec. 2, Ch. 301, L. 2005; amd. Sec. 4, Ch. 321, L. 2009; amd. Sec. 7, Ch. 317, L. 2011; amd. Sec. 20, Ch. 123, L. 2013; amd. Sec. 4, Ch. 125, L. 2013; amd. Sec. 3, Ch. 24, L. 2015; amd. Sec. 9, Ch. 4, L. 2023.

32-9-105. Nationwide mortgage licensing system for mortgage brokers, mortgage lenders, mortgage servicers, and mortgage loan originators. (1) The department may participate in the NMLS and shall require mortgage brokers, mortgage lenders, mortgage servicers, and mortgage loan originators to apply for state licensure on applications approved by the NMLS.

(2) The department may establish requirements through rulemaking as necessary to comply with the NMLS, including requirements:

(a) for payment of nonrefundable fees to apply for, maintain, and renew licenses through the NMLS;

(b) for renewal or reporting dates; and

(c) pertaining to any other activity necessary for participation in the NMLS.

(3) The department's portion of the licensing fees collected by the NMLS under this section must be deposited in the department's account in the state special revenue fund to be used for administering this part. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 6, Ch. 321, L. 2009; amd. Sec. 9, Ch. 317, L. 2011; amd. Sec. 5, Ch. 125, L. 2013; amd. Sec. 4, Ch. 24, L. 2015.

32-9-106. Simultaneous licensure. An entity may be simultaneously licensed as a mortgage lender, a mortgage servicer, and a mortgage broker if the entity meets all requirements for licensure for each license type. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 7, Ch. 321, L. 2009; amd. Sec. 10, Ch. 317, L. 2011.

32-9-107. Prelicensing education requirements for mortgage loan originators. (1) An individual seeking a mortgage loan originator's license shall complete at least 20 hours of approved education courses, which must include at least:

(a) 3 hours of training on federal law and regulations;

(b) 3 hours of training in ethics, including instruction on fraud, consumer protection, and fair lending issues; and

(c) 2 hours of training related to lending standards for the nontraditional mortgage product marketplace.

(2) In addition to the training required in subsections (1)(a), (1)(b), and (1)(c), the department may require by rule that applicants complete additional hours of training that are specific to Montana residential mortgage statutes and rules.

(3) The prelicensing education courses that comply with the requirements of subsection (1) and that are approved by the NMLS for any other state must be accepted with respect to the completion of prelicensing education requirements in Montana. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 8, Ch. 321, L. 2009; amd. Sec. 11, Ch. 317, L. 2011; amd. Sec. 6, Ch. 125, L. 2013; amd. Sec. 5, Ch. 24, L. 2015.

32-9-108. Repealed. Sec. 34, Ch. 321, L. 2009.

History: En. Sec. 5, Ch. 516, L. 2003; amd. Sec. 2, Ch. 498, L. 2007.

32-9-109. Experience requirements. (1) An individual may not act as a designated manager without a minimum of 3 years of experience working as a mortgage loan originator or in a related field.

(2) An individual may not act as a responsible individual without a minimum of 1½ years of experience working as a mortgage loan originator or in a related field.

(3) The department shall by rule establish what constitutes work in a related field. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 6, Ch. 516, L. 2003; amd. Sec. 3, Ch. 301, L. 2005; amd. Sec. 3, Ch. 498, L. 2007; amd. Sec. 9, Ch. 321, L. 2009; amd. Sec. 7, Ch. 125, L. 2013; amd. Sec. 6, Ch. 24, L. 2015.

32-9-110. Examination requirements for mortgage loan originators. (1) An individual seeking a mortgage loan originator's license shall submit to an examination.

(2) In order to meet the examination requirement referred to in subsection (1), an individual shall pass, in accordance with the standards established under this section, a qualified written exam developed by the NMLS that is administered by an approved test provider.

(3) A written examination may not be treated as a qualified written examination for purposes of this section unless the exam adequately measures the applicant's knowledge and comprehension in appropriate subject areas, including but not limited to:

(a) ethics;

(b) federal and state laws and regulations pertaining to mortgage origination; and

(c) federal and state laws and regulations pertaining to fraud, consumer protection, the nontraditional mortgage product marketplace, and fair lending issues.

(4) An individual may not be considered to have passed a qualified examination unless the individual achieves an exam score of at least 75%.

(5) An individual may retake a test three consecutive times with each consecutive test being taken at least 30 days after the previous testing date.

(6) An individual who fails three consecutive tests may not take the test for at least 6 months from the date of failing the third test.

(7) A licensed mortgage loan originator who fails to maintain a valid license for a period of 5 years shall retake the test. The 5-year period may not take into account any time during which the person is a registered mortgage loan originator. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 7, Ch. 516, L. 2003; amd. Sec. 4, Ch. 498, L. 2007; amd. Sec. 10, Ch. 321, L. 2009; amd. Sec. 8, Ch. 125, L. 2013.

32-9-111. Repealed. Sec. 18, Ch. 498, L. 2007.
History: En. Sec. 8, Ch. 516, L. 2003.

32-9-112. Application for mortgage broker, mortgage lender, mortgage servicer, and mortgage loan originator license — renewals. (1) An applicant under this part shall apply for a state license or renewal of a license on the forms prescribed by the NMLS. The department shall use the NMLS forms and policies for all licensing actions.

(2) The department may establish relationships or contracts with the NMLS or other entities designated by the NMLS to collect and maintain records and process transaction fees or other fees related to licensees or other persons subject to this part.

(3) An applicant for a license or license renewal shall furnish information to the NMLS concerning the applicant's identity, including but not limited to:

(a) fingerprints for submission to the federal bureau of investigation and any governmental agency or entity authorized to receive information for a state, national, and international criminal history background check; and

(b) personal history and experience in a form prescribed by the NMLS, including submission of authorization for the NMLS and the department to obtain:

(i) an independent credit report from a consumer reporting agency described in section 603(p) of the Fair Credit Reporting Act, 15 U.S.C. 1681a(p); and

(ii) information related to administrative, civil, or criminal findings by a governmental jurisdiction.

(4) For the purposes of this section and to reduce the points of contact that the federal bureau of investigation may have to maintain for purposes of subsection (3), the department

may use the NMLS as a channeling agent for requesting information from and distributing information to the United States department of justice or other governmental agencies.

(5) For the purposes of this section and to reduce the points of contact that the department may have to maintain for purposes of subsection (3), the department may use the NMLS as a channeling agent for requesting and distributing information to and from any source directed by the department. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 11, Ch. 321, L. 2009; amd. Sec. 12, Ch. 317, L. 2011; amd. Sec. 9, Ch. 125, L. 2013; amd. Sec. 7, Ch. 24, L. 2015.

32-9-113. Control persons — application for license — renewal. For the department to consider an entity for a state license or license renewal, each person with control, as defined in 32-9-103, of the entity is required to independently meet the requirements established in 32-9-120(1)(a) through (1)(c) and (1)(g). *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 12, Ch. 321, L. 2009; amd. Sec. 13, Ch. 317, L. 2011; amd. Sec. 8, Ch. 24, L. 2015.

32-9-114. Repealed. Sec. 38, Ch. 317, L. 2011.

History: En. Sec. 14, Ch. 321, L. 2009.

32-9-115. Repealed. Sec. 34, Ch. 321, L. 2009.

History: En. Sec. 9, Ch. 516, L. 2003; amd. Sec. 2, Ch. 136, L. 2005; amd. Sec. 5, Ch. 498, L. 2007.

32-9-116. Employment of mortgage loan originator. (1) A mortgage loan originator may transact business for only one employing mortgage broker or one employing mortgage lender licensed in accordance with the provisions of this part.

(2) If the employment of a mortgage loan originator is terminated, the sponsoring mortgage broker or mortgage lender shall remove sponsorship of the mortgage loan originator on the NMLS within 5 business days of the termination. The mortgage loan originator's license must be placed in "Approved-Inactive" status until the license is sponsored by a mortgage broker or mortgage lender. If at the end of the next renewal period the license is not sponsored by a mortgage broker or mortgage lender, it must be automatically placed in "Terminated-Expired" status for failure to renew. The removal of sponsorship of the license of any mortgage loan originator extinguishes the right of the mortgage loan originator to engage in any residential mortgage loan origination activity until NMLS procedures have been followed to sponsor the license. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 10, Ch. 516, L. 2003; amd. Sec. 13, Ch. 321, L. 2009; amd. Sec. 14, Ch. 317, L. 2011; amd. Sec. 10, Ch. 125, L. 2013.

32-9-117. Fees — disposition of fees — rulemaking. (1) (a) Application fees are:

(i) mortgage broker, $500;

(ii) mortgage broker branch, $250;

(iii) mortgage lender or mortgage servicer, $750;

(iv) mortgage lender branch or mortgage servicer branch, $250; and

(v) mortgage loan originator, $400.

(b) A mortgage broker entity owned by a Montana-licensed mortgage loan originator shall pay a license application fee of $100.

(2) All application fees must be paid through the NMLS and are not refundable.

(3) The department shall by rule establish the fees for renewal applications and reinstatement of expired licenses. The fees set by the department must be commensurate with the costs of the program.

(4) The department's portion of the fees collected under this section must be deposited in the department's state special revenue fund to be used by the department in administering the provisions of this part. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 11, Ch. 516, L. 2003; amd. Sec. 1, Ch. 368, L. 2005; amd. Sec. 6, Ch. 498, L. 2007; amd. Sec. 15, Ch. 321, L. 2009; amd. Sec. 15, Ch. 317, L. 2011; amd. Sec. 11, Ch. 125, L. 2013.

32-9-118. Continuing education requirements for mortgage loan originators. (1) All mortgage loan originators shall complete and submit to the NMLS evidence of at least 8 hours of continuing education every year at the time they submit their license renewal applications. The 8 hours of continuing education must be obtained in approved education courses.

(2) The 8 hours of education must include at least:

(a) 3 hours of training on federal laws and regulations;

(b) 2 hours of training in ethics, including instruction on fraud prevention, consumer protection, and fair lending issues; and

(c) 2 hours of training related to lending standards for the nontraditional mortgage product marketplace.

(3) A person who has successfully completed the education requirements that comply with the requirements of subsections (1) and (2) and that are approved by the NMLS for any other state must be given credit toward completion of continuing education requirements in Montana.

(4) Except as provided in subsection (6), a licensed mortgage loan originator may receive credit for a continuing education course only in the year in which the course is taken and may not take the same approved course in the same or successive years to meet the annual requirements for continuing education.

(5) A licensed mortgage loan originator who is an approved instructor of an approved continuing education course may receive credit for the licensed mortgage loan originator's own annual continuing education requirement at the rate of 2 hours credit for every 1 hour taught.

(6) A licensed mortgage loan originator who subsequently becomes unlicensed shall complete the continuing education requirements for the last year in which the license was held prior to issuance of a new or renewed license. The continuing education requirements of this subsection are not subject to the provision of subsection (4) that credit may be given only in the year a course is taken. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 12, Ch. 516, L. 2003; amd. Sec. 18, Ch. 321, L. 2009; amd. Sec. 16, Ch. 317, L. 2011; amd. Sec. 14, Ch. 125, L. 2013.

32-9-119. Repealed. Sec. 34, Ch. 321, L. 2009.

History: En. Sec. 10, Ch. 498, L. 2007.

32-9-120. Denial of mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator license application or license renewal. (1) The department may not issue or renew any mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator license if any of the following facts are found during the application procedure:

(a) the applicant has ever had a mortgage loan originator license or an equivalent license revoked in any governmental jurisdiction. A subsequent formal vacation of a revocation means that the revocation may not be considered a revocation. The department may by order vacate a revocation of a license and enter an appropriate order.

(b) the applicant has been convicted of or pleaded guilty or nolo contendere to a felony in a domestic, foreign, or military court during the 7-year period preceding the date of the application for licensing or renewal or at any time preceding the date of application if the felony involved an act of fraud, dishonesty, a breach of trust, or money laundering. The pardon or expungement of a conviction is not a conviction for the purposes of this subsection (1)(b). When determining the eligibility of the applicant for licensure under subsection (1)(c) or this subsection (1)(b), the department may consider the underlying crime, facts, or circumstances of a pardoned or expunged felony conviction.

(c) the applicant has failed to demonstrate financial responsibility, character, and general fitness to command the confidence of the community and to warrant a determination that the mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator will operate honestly, fairly, and efficiently within the purposes of this section;

(d) the applicant has not provided and maintained the surety bond as required pursuant to 32-9-123;

(e) the applicant has not completed the prelicensing education requirement described in 32-9-107;

(f) the applicant has not passed a written test that meets the test requirements described in 32-9-110;

(g) the applicant made a material misstatement of fact or material omission of fact in the application;

(h) the applicant has failed to meet the mortgage servicer capital requirements provided in 32-9-206;

(i) the applicant has failed to meet the minimum mortgage lender net worth requirements provided in 32-9-172; or

(j) the applicant has been found to have violated:

(i) any rule of conduct for persons taking the mortgage loan originator national or state test under the federal Secure and Fair Enforcement for Mortgage Licensing Act; or

(ii) the nationwide multistate licensing system industry terms of use as they pertain to enrolling, scheduling, or taking the mortgage loan originator national or state test under the Secure and Fair Enforcement for Mortgage Licensing Act.

(2) The department may consider an application abandoned if an applicant fails to provide or respond to a request for additional information within the time period specified by the department by rule.

(3) For purposes of subsection (1)(b), a pardoned or expunged felony conviction does not necessitate denial of the license application. The department may consider the underlying crime, facts, or circumstances of a pardoned or expunged felony conviction when determining the eligibility of an applicant for licensure under subsection (1)(b) or (1)(c). Whether a particular crime is classified as a felony must be determined by the law of the jurisdiction in which an individual is convicted. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 17, Ch. 321, L. 2009; amd. Sec. 17, Ch. 317, L. 2011; amd. Sec. 15, Ch. 125, L. 2013; amd. Sec. 4, Ch. 65, L. 2019; amd. Sec. 10, Ch. 4, L. 2023.

32-9-121. Records maintenance. (1) Licensees shall maintain books, accounts, records, and copies of residential mortgage loan files and escrow account records that are necessary to enable the department to determine whether a licensee is in compliance with the applicable laws and rules. The materials must be maintained in accordance with generally accepted accounting principles and good business practices. Whenever a licensee's usual business location is outside of this state the licensee shall, at its election, either maintain its books and records at a location in this state or reimburse the department for expenses incurred, including but not limited to staff time, transportation, food, and lodging expenses, relating to an examination or investigation under this part.

(2) A mortgage broker, mortgage lender, or mortgage servicer shall maintain a residential mortgage file for a minimum of 5 years from the date of the last activity pertaining to the file. A mortgage broker, mortgage lender, or mortgage servicer shall maintain trust account or escrow account records for a minimum of 5 years.

(3) An entity that ceases operation as a licensee under the provisions of this part shall:

(a) 30 days prior to the discontinuance of business, notify the department of the physical location where required records will be preserved; and

(b) designate a custodian of records and notify the department of the name, physical address, electronic mail address, and telephone number of the custodian of records. The custodian of records shall preserve records required under this part and allow the department access for examination and investigation purposes upon request of the department.

(4) The department shall adopt rules to control the maintenance, storage, transfer, and destruction of records after a licensee ceases operation. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 13, Ch. 516, L. 2003; amd. Sec. 3, Ch. 136, L. 2005; amd. Sec. 7, Ch. 498, L. 2007; amd. Sec. 19, Ch. 321, L. 2009; amd. Sec. 18, Ch. 317, L. 2011; amd. Sec. 16, Ch. 125, L. 2013.

32-9-122. Designated manager and branch office license requirements. (1) A mortgage broker, mortgage lender, or mortgage servicer shall apply for a license for a main office and for every branch office through the NMLS and maintain a unique identifier. All locations must be within the United States or a territory, including Puerto Rico and the U.S. Virgin Islands.

(2) A mortgage broker or mortgage lender shall designate to the NMLS an individual who is licensed as a mortgage loan originator as the designated manager of the entity. The designated manager is responsible for the mortgage origination activity conducted by all mortgage loan originators, employees, independent contractors, and agents assigned to the entity.

(3) A designated manager must have 3 years of experience as either a mortgage loan originator or a registered mortgage loan originator.

(4) A designated manager is responsible for the operation of the entity at all physical and remote locations under the designated manager's full charge, supervision, and control.

(5) A mortgage broker or mortgage lender is responsible for the conduct of its employees, including for violations of federal or state laws, rules, or regulations.

(6) A designated manager is responsible for conduct that violates federal or state laws, rules, or regulations by the designated manager and each employee of the mortgage broker or mortgage lender.

(7) If the designated manager ceases to act in that capacity, within 15 days the mortgage broker or mortgage lender shall designate another individual licensed as a mortgage loan originator as designated manager and shall submit information to the NMLS establishing that the subsequent designated manager complies with the provisions of this part.

(8) If the employment of a designated manager is terminated, the mortgage broker or mortgage lender shall remove the sponsorship of the designated manager on the NMLS within 5 business days of the termination.

(9) A mortgage servicer is responsible for the acts and omissions of its employees, agents, and independent contractors acting in the course and scope of their employment, agency, or contract. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 14, Ch. 516, L. 2003; amd. Sec. 2, Ch. 368, L. 2005; amd. Sec. 8, Ch. 498, L. 2007; amd. Sec. 20, Ch. 321, L. 2009; amd. Sec. 19, Ch. 317, L. 2011; amd. Sec. 17, Ch. 125, L. 2013; amd. Sec. 9, Ch. 24, L. 2015; amd. Sec. 5, Ch. 65, L. 2019; amd. Sec. 11, Ch. 4, L. 2023.

32-9-123. Surety bond requirement — notice of legal action. (1) (a) A mortgage loan originator must be covered by a surety bond in accordance with this section. If a mortgage loan originator is an employee of a licensed mortgage lender or mortgage broker, the surety bond of the licensed mortgage lender or mortgage broker may be used in lieu of a mortgage loan originator's surety bond.

(b) The bond must run to the state of Montana as obligee and must run first to the benefit of the borrower and then to the benefit of the state and any person who suffers loss by reason of the obligor's or its loan originator's violation of any provision of this part or rules adopted under this part. The department shall use the proceeds of the surety bonds to reimburse borrowers, the department, or bona fide third parties who successfully demonstrate a financial loss because of an act of a mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator that violates any provision of this part.

(2) (a) An entity licensed as a mortgage broker, mortgage lender, and mortgage servicer is required to maintain one surety bond for each entity license.

(b) The amount of the required surety bond must be calculated by combining the annual loan production amounts for all persons originating residential mortgage loans and for all business locations of the mortgage broker or mortgage lender and must be in the following amount:

(i) $25,000 for a combined annual loan production that does not exceed $50 million a year;

(ii) $50,000 for annual loan production of more than $50 million but not exceeding $100 million a year; or

(iii) $100,000 for annual loan production of more than $100 million a year.

(c) The amount of the required surety bond for a mortgage servicer must be calculated on the mortgage servicer's total unpaid principal balance of residential mortgage loans as of December 31. The amount of the surety bond must be in the following amount:

(i) $75,000 for an unpaid principal balance that does not exceed $25 million a year;

(ii) $150,000 for an unpaid principal balance of more than $25 million but not exceeding $100 million a year;

(iii) $250,000 for an unpaid principal balance of more than $100 million but not exceeding $500 million a year; or

(iv) $350,000 for an unpaid principal balance of more than $500 million a year.

(3) A mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator shall give notice to the department through the NMLS within 15 days of the mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator obtaining knowledge of the initiation of an investigation or the entry of a judgment in a criminal or civil action. The notice must be given if the investigation or the legal action is in any state and involves a mortgage

broker, a mortgage lender, a mortgage servicer, a mortgage loan originator, or anyone having an ownership interest in a mortgage broker entity, mortgage lender entity, or mortgage servicer entity. In the case of a legal action, the notice must include a copy of the criminal or civil judgment.

(4) (a) An obligor shall give written notice to the department through the NMLS of any action that may be brought against it by any creditor or borrower when the action:

(i) is brought under this part;

(ii) involves a claim against the bond filed with the department for the purposes of compliance with this section; or

(iii) involves a claim for damages in excess of $20,000 for a mortgage broker or mortgage loan originator or $200,000 for a mortgage lender or mortgage servicer.

(b) An obligor shall give written notice to the department through the NMLS of any judgment that may be entered against it by any creditor or any borrower or prospective borrower.

(c) The written notice must provide details sufficient to identify the action or judgment and must be submitted within 30 days after the commencement of any action or within 30 days after the entry of any judgment.

(5) A corporate surety shall, within 10 days after it pays any claim or judgment to any claimant, give written notice to the department of the payment with details sufficient to identify the claimant and the claim or judgment paid. Whenever the principal sum of a required bond is reduced by one or more recoveries or payments on the bond, the obligor shall furnish a new or additional bond so that the total or aggregate principal sum of the bond or bonds equals the sum required under this section or the obligor shall furnish an endorsement duly executed by the corporate surety reinstating the bond to the required principal sum.

(6) A bond filed with the department or with the NMLS for the purpose of compliance with this section may not be canceled by the obligor or the corporate surety except upon written notice to the department through the NMLS. The cancellation may not take effect until 30 days after receipt by the department of the notice. The cancellation is effective only with respect to any occurrence after the effective date of the cancellation. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 15, Ch. 516, L. 2003; amd. Sec. 9, Ch. 498, L. 2007; amd. Sec. 22, Ch. 321, L. 2009; amd. Sec. 20, Ch. 317, L. 2011; amd. Sec. 18, Ch. 125, L. 2013; amd. Sec. 10, Ch. 24, L. 2015; amd. Sec. 6, Ch. 65, L. 2019.

32-9-124. Prohibitions — required disclosure. (1) A mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator may not do any of the following:

(a) retain original documents owned by the borrower and submitted in connection with the loan application;

(b) directly or indirectly employ any scheme to defraud or mislead a borrower, a mortgage broker, a mortgage lender, a mortgage servicer, or any other person;

(c) make any misrepresentation or deceptive statement in connection with a residential mortgage loan, including but not limited to interest rates, points, costs at closing, or other financing terms or conditions;

(d) fail to pay a bona fide third party within 30 days after recording of the loan closing documents or within 90 days after completion of the bona fide third-party service, whichever is earlier, unless otherwise agreed by the parties;

(e) accept any fees or compensation in excess of those allowed by state or federal law;

(f) sign a borrower's application or related documents on behalf of or in lieu of another mortgage broker, mortgage lender, or mortgage loan originator;

(g) assist or aid and abet any person in the conduct of business under this part without a valid license as required under this part;

(h) conduct any business covered by the provisions of the Secure and Fair Enforcement for Mortgage Licensing Act, Title V of the Housing and Economic Recovery Act of 2008, Public Law 110-289, without holding a valid license as required under this part;

(i) fail to comply with this part or rules promulgated under this part or fail to comply with any other state or federal laws, including the rules and regulations adopted pursuant to those laws, applicable to any business authorized by or conducted under this part;

(j) fail to account for or deliver to any person any funds, documents, or other thing of value obtained in connection with a mortgage loan that the mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator is not entitled to retain under the circumstances;

(k) refuse to permit an investigation or examination of the mortgage broker's, mortgage lender's, mortgage servicer's, or mortgage loan originator's books and records or refuse to comply with a department subpoena or subpoena duces tecum;

(l) knowingly withhold, abstract, remove, mutilate, destroy, alter, or keep secret any books, records, computer records, or other information from the department; or

(m) negligently make any false statement or knowingly and willfully make any omission of material fact in connection with any information or reports filed with a government agency or the NMLS or in connection with any investigation conducted by the department or another governmental agency.

(2) Within 3 business days of taking an application, the mortgage loan originator working for a mortgage broker, in addition to other disclosures required by this part and other state and federal laws, shall provide to the borrower a written disclosure as prescribed by the department by rule.

(3) A mortgage broker or mortgage lender may not accept any fees or compensation that were not disclosed as required by state or federal law.

(4) A mortgage broker or mortgage lender may not charge or receive, directly or indirectly, fees for assisting a borrower in obtaining a mortgage until all of the services that the mortgage broker or mortgage lender has agreed to perform for the borrower are completed.

(5) A mortgage broker or mortgage lender may not charge or receive an amount in excess of the amount allowed by federal law. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 16, Ch. 516, L. 2003; amd. Sec. 11, Ch. 498, L. 2007; amd. Sec. 25, Ch. 321, L. 2009; amd. Sec. 23, Ch. 317, L. 2011; amd. Sec. 20, Ch. 125, L. 2013.

32-9-125. Repealed. Sec. 33, Ch. 125, L. 2013.

History: En. Sec. 17, Ch. 516, L. 2003; amd. Sec. 12, Ch. 498, L. 2007; amd. Sec. 26, Ch. 321, L. 2009; amd. Sec. 26, Ch. 317, L. 2011.

32-9-126. Revocation, suspension, conditioning, and reinstatement of licenses. (1) The department, upon giving a mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator licensee 14 days' written notice, which includes a statement of the grounds for the proposed suspension, conditioning, or revocation, and informing the licensee that the licensee has the right to be heard at an administrative hearing if requested by the licensee, may suspend, condition, or revoke a license if it finds that the licensee has violated any provision of this part or any rule adopted under this part.

(2) The license of a licensee that refuses to make documents and records relating to the operation of the licensee available upon request by the department must be summarily suspended.

(3) A revocation, suspension, or surrender of a license does not relieve the licensee from civil or criminal liability for acts committed prior to the revocation, suspension, or surrender of the license.

(4) The department may reinstate any suspended license if the suspended licensee has complied with all the reinstatement conditions set forth at the time the license was suspended and if the licensee is otherwise qualified to have the license reinstated.

(5) The department may by order vacate a revocation of a license and enter an appropriate order.

(6) The department may refuse to accept a licensee's offer to surrender a license under the following circumstances:

(a) a final order has been issued in an enforcement action and the licensee has not fully complied with the order regardless of whether compliance is yet due;

(b) the licensee has violated or is under investigation for a suspected violation of this part or any rule adopted under this part;

(c) there is an enforcement action or complaint pending against the licensee; or

(d) the licensee has not made arrangements satisfactory to the department regarding loans in process at the time of the offer of surrender.

(7) A revocation, suspension, or surrender of a license does not impair or affect the obligation of a preexisting lawful contract between the licensee and any person, including a borrower.

(8) In the event of a revoked, suspended, or surrendered mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator license, fees may not be refunded by the department. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 18, Ch. 516, L. 2003; amd. Sec. 15, Ch. 498, L. 2007; amd. Sec. 27, Ch. 321, L. 2009; amd. Sec. 27, Ch. 317, L. 2011; amd. Sec. 21, Ch. 125, L. 2013.

32-9-127. Repealed. Sec. 38, Ch. 317, L. 2011.

History: En. Sec. 16, Ch. 321, L. 2009.

32-9-128. Registration and registered agent of foreign entities — service of process — venue. (1) A foreign mortgage broker, mortgage lender, or mortgage servicer shall register to do business in this state as a foreign corporation, limited liability company, limited liability partnership, or limited partnership with the secretary of state.

(2) A foreign mortgage broker, mortgage lender, or mortgage servicer shall provide the name and address of its registered agent for service of process to the department in order to be licensed in this state and shall notify the department in writing within 5 days of a change in the licensee's registered agent's name or address.

(3) For purposes of this part, the department is considered to have complied with the requirements of law concerning service of process upon sending by common courier with tracking capability any notice required or permitted to a licensee under this part, postage prepaid and addressed to the last-known address of the licensee's registered agent for service of process on file with the department, the last-known address of the licensee on file with the department for an in-state licensee, or in the case of an unlicensed person, the last-known address of the person.

(4) In a judicial action, suit, or proceeding arising under this part or any administrative rule adopted pursuant to this part between the department and a licensee who does not maintain a physical office in this state, venue must be exclusively in Lewis and Clark County. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 21, Ch. 321, L. 2009; amd. Sec. 28, Ch. 317, L. 2011; amd. Sec. 7, Ch. 65, L. 2019.

32-9-129. Loan processors and underwriters. A person engaging in loan processor or underwriter activities may not represent to the public, through advertising or other means of communication, that the person can or will perform any of the activities of a mortgage loan originator. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 5, Ch. 321, L. 2009; amd. Sec. 29, Ch. 317, L. 2011; amd. Sec. 22, Ch. 125, L. 2013; amd. Sec. 11, Ch. 24, L. 2015.

32-9-130. Department authority — rulemaking. (1) The department shall adopt rules necessary to carry out the intent and purposes of this part. The rules adopted are binding on all licensees and enforceable as provided under this part.

(2) The rules must address:

(a) revocation or suspension of licenses for cause;

(b) investigation of applicants, licensees, and unlicensed persons alleged to have violated a provision of this part and handling of complaints made by any person in connection with any business transacted by a licensee;

(c) (i) ensuring that all persons are informed of their right to contest a decision by the department under the Montana Administrative Procedure Act; and

(ii) holding contested case hearings pursuant to the Montana Administrative Procedure Act and issuing cease and desist orders, orders of restitution, and orders for the recovery of administrative costs; and

(d) establishing fees for license renewals.

(3) The department may adopt rules
defining supervisory requirements for designated managers.

(4) The department may seek a writ or order restraining or enjoining, temporarily or permanently, any act or practice violating any provision of this part.

(5) (a) For the purposes of investigating violations or complaints arising under this part or for the purposes of examination, the department may review, investigate, or examine any licensee, service provider, or person subject to this part as often as necessary in order to carry out the purposes of this part.

(b) The commissioner of banking and financial institutions may direct, subpoena, or order the attendance of and may examine under oath any person whose testimony may be required about the subject matter of any examination or investigation and may direct, subpoena, or order the person to produce books, accounts, records, files, and any other documents the commissioner of banking and financial institutions considers relevant to the inquiry.

(6) Each licensee, service provider, or person subject to this part shall make available to the department upon request the documents and records relating to the operations of the licensee or person. The department may access the documents and records and may interview the officers, principals, mortgage loan originators, employees, independent contractors, service providers, agents, or customers of the licensee or person concerning the business of the licensee or person or any other person having knowledge that the department considers relevant.

(7) (a) The department may conduct investigations and examinations for the purposes of initial licensing, license renewal, license suspension, license conditioning, license revocation, or license termination or to determine compliance with this part.

(b) The department has the authority to access, receive, and use any books, accounts, records, files, documents, information, or evidence, including but not limited to:

(i) criminal, civil, and administrative history information, including confidential criminal justice information as defined in 44-5-103;

(ii) personal history and experience information, including independent credit reports obtained from a consumer reporting agency described in section 603(p) of the Fair Credit Reporting Act, 15 U.S.C. 1681, et seq.; and

(iii) any other documents, information, or evidence the department considers relevant to an inquiry or investigation regardless of the location, possession, control, or custody of the documents, information, or evidence.

(8) (a) The total cost for any examination or investigation of a service provider or unlicensed entity must be in accordance with fees determined by the department by rule pursuant to this section and may include expenses for necessary travel outside the state for the purposes of conducting the examination or investigation. The fees set by the department must be commensurate with the cost of the examination or investigation of the entity. All fees collected under this section must be deposited in the department's account in the state special revenue fund to be used by the department to cover the department's cost of conducting examinations and investigations.

(b) The cost of an examination or investigation must be paid by the unlicensed person or service provider within 30 days after the date of the invoice. A person may not be licensed until the cost of examination or investigation is paid.

(9) (a) The department may:

(i) exchange information with federal and state regulatory agencies, the attorney general, the attorney general's consumer protection office, and the legislative auditor;

(ii) exchange information other than confidential information with the mortgage asset research institute, inc., and other similar organizations; and

(iii) refer any matter to the appropriate law enforcement agency for prosecution of a violation of this part.

(b) To carry out the purposes of this section, the department may:

(i) enter into agreements or relationships with other government officials or regulatory associations to improve efficiencies and reduce the regulatory burden by sharing resources, adopting standardized or uniform methods or procedures, and sharing documents, records, information, or evidence obtained under this part, including agreements to maintain the confidentiality of information under laws, rules, or evidentiary privileges of another state, the federal government, or this state;

(ii) retain attorneys, accountants, or other professionals and specialists as examiners, auditors, or investigators to conduct or assist in the conduct of examinations or investigations;

(iii) use, hire, contract, or employ public or privately available analytical systems, methods, or software to examine or investigate the licensee or person subject to this part;

(iv) accept and rely on examination or investigation reports by other government officials, within or outside of this state, without the loss of any privileges or confidentiality protection afforded by state or federal laws, rules, or evidentiary privileges that cover those reports;

(v) accept audit reports made by an independent certified public accountant for the licensee or person subject to this part if the examination or investigation covers at least in part the same general subject matter as the audit report and may incorporate the audit report in the report of the examination, report of the investigation, or other writing of the department under this part; and

(vi) assess against the unlicensed person or service provider subject to this part the costs incurred by the department in conducting the examination or investigation.

(c) Except as provided in 32-9-160 and subsection (9)(a)(i) of this section, the department shall treat all confidential criminal justice information as confidential unless otherwise required by law.

(10) Pursuant to section 1508(d) of the Secure and Fair Enforcement for Mortgage Licensing Act, Title V of the Housing and Economic Recovery Act of 2008, Public Law 110-289, the department is authorized to:

(a) supervise and enforce the provisions of this part, including the suspension, termination, revocation, or nonrenewal of a license for violation of state or federal law;

(b) participate in the NMLS;

(c) ensure that all mortgage broker, mortgage lender, and mortgage loan originator applicants under this part apply for state licensure and pay any required nonrefundable fees to and maintain a valid unique identifier issued by the NMLS; and

(d) regularly report violations of state or federal law and enforcement actions to the NMLS. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 19, Ch. 516, L. 2003; amd. Sec. 4, Ch. 136, L. 2005; amd. Sec. 16, Ch. 498, L. 2007; amd. Sec. 31, Ch. 321, L. 2009; amd. Sec. 30, Ch. 317, L. 2011; amd. Sec. 23, Ch. 125, L. 2013; amd. Sec. 13, Ch. 24, L. 2015; amd. Sec. 8, Ch. 65, L. 2019; amd. Sec. 12, Ch. 4, L. 2023.

Cross-References

Department of administration, Title 2, ch. 15, part 10.

32-9-131. Repealed. Sec. 18, Ch. 498, L. 2007.

History: En. Sec. 20, Ch. 516, L. 2003.

32-9-132. Injunctions — receivers. (1) Whenever the department has reasonable cause to believe that any person is violating or is threatening to violate this part or a rule adopted under this part, the department may, in addition to all actions provided for in this part and without prejudice to those actions, seek an order requiring the person to desist or to refrain from the violation.

(2) An action may be brought by the department in the district court of the first judicial district, Lewis and Clark County, to enjoin the person from engaging in or continuing the violation or from doing any act or acts in furtherance of the violation. In any action, a preliminary or final injunction may be ordered as considered proper.

(3) In addition to all other means provided by law for the enforcement of a restraining order or injunction, the court in which the action is brought may impound and appoint a receiver for the property and business of the defendant, including books, papers, documents, or records pertaining to the property or business, or as much of the property or business as the court considers reasonably necessary to prevent violations of this part. The receiver, when appointed and qualified, has the powers and duties as to custody, collection, administration, winding up, and liquidation of the property and business that are conferred upon the receiver by the court.

History: En. Sec. 21, Ch. 516, L. 2003.

Cross-References

Injunctions, Title 27, ch. 19.

32-9-133. Penalties — restitution. (1) If the department finds, after providing a 14-day written notice that includes a statement of alleged violations and a hearing or an opportunity for hearing, as provided in the Montana Administrative Procedure Act, that any person, licensee, service provider, or officer, agent, employee, or representative of the person or licensee, whether licensed or unlicensed, has violated any of the provisions of this part, has failed to comply with the rules, instructions, or orders promulgated by the department, has failed or refused to make required reports to the department, has furnished false information to the department, or has operated without a required license, the department may impose a civil penalty not to exceed $5,000 for the first violation and not to exceed $10,000 for each subsequent violation.

(2) The department may issue an order:

(a) requiring restitution;

(b) requiring reimbursement of the department's cost in bringing the administrative action; and

(c) revoking, conditioning, or suspending the right of the person or licensee, directly or through a service provider, officer, agent, employee, or representative, to do business in this state as a licensee or to engage in the mortgage broker, mortgage lender, mortgage servicer, or mortgage loan origination business.

(3) Any person who directly or indirectly controls an entity liable under subsection (1), any partner, officer, director, or person occupying a similar status or performing similar functions of the entity, and any person who participates or materially aids in the violation is liable jointly and severally with and to the same extent as the person committing the violation. In addition, each person committing the violation or aiding in the violation is jointly and severally liable if the person committing the violation or aiding in the violation knew or in the exercise of reasonable care should have known of the existence of the facts by reason of which the liability is alleged to exist. There must be contribution between or among the severally liable persons.

(4) The fines must be deposited in the department's account in the state special revenue fund and used to administer the provisions of this part. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 22, Ch. 516, L. 2003; amd. Sec. 17, Ch. 498, L. 2007; amd. Sec. 32, Ch. 321, L. 2009; amd. Sec. 31, Ch. 317, L. 2011; amd. Sec. 24, Ch. 125, L. 2013; amd. Sec. 9, Ch. 65, L. 2019.

Cross-References

Due process of law, Art. II, sec. 17, Mont. Const.
Contested cases — notice, 2-4-601.
Contested cases — hearing, 2-4-612.
Fund structure, 17-2-102.

32-9-134. License renewal — rulemaking. (1) All persons licensed under this part are required to renew their licenses by December 31 of each year.

(2) A renewal application for a mortgage broker, mortgage lender, mortgage servicer, or mortgage loan originator must demonstrate that:

(a) the licensee continues to meet the standards for licensure under this part;

(b) a mortgage loan originator has satisfied annual continuing education requirements pursuant to 32-9-118; and

(c) the licensee has paid all required fees for renewal of the license, all outstanding examination fees and investigation fees, and any civil penalties.

(3) Any license not renewed by December 31 expires on December 31. The department may adopt rules regarding requirements for renewal applications and the procedures for the reinstatement of expired licenses consistent with the standards established by the NMLS.

History: En. Sec. 12, Ch. 125, L. 2013.

32-9-135. Independent contractor entity — responsible individual — loan processor or underwriter. (1) An independent contractor entity may not offer or engage in clerical or support duties with respect to any dwelling or residential real estate in this state unless the independent contractor entity obtains and maintains a valid mortgage broker license through the NMLS.

(2) An independent contractor entity shall apply for a mortgage broker license through the NMLS for its main office and for every branch office where clerical or support duties are conducted.

(3) An independent contractor entity shall designate a responsible individual for each main office and each branch office. The responsible individual must be an employee of the independent contractor entity.

(4) The responsible individual is responsible for the operation of the business at the responsible individual's place of employment under the responsible individual's full charge, supervision, and control.

(5) An independent contractor entity is responsible for the conduct and omissions of its employees, agents, and independent contractors, including for violations of federal or state laws, rules, or regulations.

(6) A responsible individual is responsible for conduct that violates federal or state laws, rules, or regulations. The responsible individual's responsibility includes conduct by the responsible individual and each employee and agent of the independent contractor entity at the location that the responsible individual manages.

(7) If the responsible individual ceases to act in that capacity, the independent contractor entity shall within 15 days designate as responsible individual another individual who is a licensed or registered mortgage loan originator and shall submit information to the NMLS establishing that the subsequent responsible individual is in compliance with the provisions of this part.

(8) If the employment of a responsible individual is terminated, the independent contractor entity shall remove the sponsorship of the responsible individual on the NMLS within 5 business days of the termination.

(9) An individual who is employed by an independent contractor entity and who performs only clerical or support duties and does so at the direction of and subject to the supervision and instruction of a responsible individual is not required to be licensed under this part.

History: **En. Sec. 12, Ch. 24, L. 2015.**

32-9-136 through 32-9-140 reserved.

32-9-141. Investigations by department — subpoenas — oaths — examination of witnesses and evidence. (1) For the purposes of this part, the department or the department's authorized representatives must be given free access to the offices and places of business and files of all licensees and their service providers. The department may investigate any matter, upon complaint or otherwise, if it appears that a person has engaged in or offered to engage in any act or practice that is in violation of any provision of this part or any rule adopted or order issued by the department pursuant to this part.

(2) The department may issue subpoenas to compel the attendance of witnesses and the production of documents, papers, books, records, and other evidence before it in any matter over which it has jurisdiction, control, or supervision pertaining to this part. The department may administer oaths and affirmations to a person whose testimony is required.

(3) If a person refuses to obey a subpoena or to give testimony or produce evidence as required by the subpoena, a judge of the district court of Lewis and Clark County or the county in which the licensed premises are located may, upon application and proof of the refusal, issue a subpoena or subpoena duces tecum for the witness to appear before the department to give testimony and produce evidence as may be required. The clerk of court shall then issue the subpoena, as directed, under the seal of the court, requiring the person to whom it is directed to appear at the time and place designated in the subpoena.

(4) If a person served with a subpoena refuses to obey the subpoena or to give testimony or produce evidence as required by the subpoena, the department may proceed under the contempt provisions of Title 3, chapter 1, part 5.

(5) Failure to comply with the requirements of a court-ordered subpoena is punishable pursuant to 45-7-309.

History: **En. Sec. 13, Ch. 498, L. 2007; amd. Sec. 10, Ch. 65, L. 2019.**

Cross-References

Oaths, Title 1, ch. 6.

Subpoenas, Title 26, ch. 2, part 1.

32-9-142. Cease and desist orders. (1) If it appears to the department that a person has engaged in or is about to engage in any act or practice constituting a violation of any provision of this part or any rule adopted or order issued by the department pursuant to this part, the department may issue an order directing the person to cease and desist from continuing the act or practice after reasonable notice and opportunity for a hearing. The order may apply only to the alleged act or practice constituting a violation of this chapter. The department may issue a temporary order pending the hearing that:

(a) remains in effect until 10 days after the hearings examiner issues proposed findings of fact and conclusions of law and a proposed order; or

(b) becomes final if the person to whom notice is addressed does not request a hearing within 10 days after receipt of the notice.

(2) A violation of an order issued pursuant to this section is subject to the penalty provisions of this part.

History: En. Sec. 14, Ch. 498, L. 2007.

32-9-143 and 32-9-144 reserved.

32-9-145. Escrow fund. (1) An escrow fund authorized for any purpose by a mortgage loan contract is subject to applicable state and federal requirements. Money received from a borrower by a mortgage lender or mortgage servicer licensed under this part must be considered as held in trust immediately upon receipt. The mortgage lender or mortgage servicer shall place escrow funds in a depository institution prior to the end of the third business day following their receipt.

(2) An escrow fund account must be a separate account established to hold only borrowers' funds. The account must be designated and maintained for the benefit of borrowers. Escrow funds may not be commingled with any other funds.

(3) Escrow funds must be kept in the segregated account until disbursement. Money maintained in an escrow fund account is exempt from execution, attachment, or garnishment.

(4) A licensee may not encumber the corpus of an escrow fund account or commingle other operating funds with account funds.

(5) An escrow fund account may be used only for:

(a) a payment authorized by the borrower or the mortgage loan contract or required by federal or state law;

(b) a refund to the borrower;

(c) transfer to a depository institution;

(d) transfer to the appropriate mortgage lender or mortgage servicer in the case of a transfer of servicing;

(e) a purpose authorized by the mortgage loan contract; or

(f) purposes of complying with an order issued by the commissioner or a court.

(6) Accounting for escrow funds must be performed in compliance with the aggregate accounting rules established in regulation X, 24 CFR 3500, and in compliance with 71-1-115. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 23, Ch. 321, L. 2009; amd. Sec. 32, Ch. 317, L. 2011.

32-9-146 and 32-9-147 reserved.

32-9-148. Disclosure of mortgage costs by mortgage lender. (1) A mortgage lender shall disclose the terms of the loan to the borrower in compliance with the disclosure requirements of the federal Real Estate Settlement Procedures Act of 1974, 12 U.S.C. 2601, et seq., the federal Truth in Lending Act, 15 U.S.C. 1601, et seq., and any regulations promulgated under those acts.

(2) A mortgage lender shall disclose the terms of any prepayment penalty on the mortgage loan, including the amount of the prepayment penalty or the formula for calculating the prepayment penalty. A mortgage lender shall comply with federal laws and rules regarding prepayment penalties.

(3) A licensed mortgage lender may not require a borrower to pay any fees or charges prior to the mortgage loan closing, except:

(a) charges to be incurred by the mortgage lender on behalf of the borrower for services from third parties necessary to process the application, such as credit reports and appraisals;

(b) an application fee;

(c) an interest rate lock-in fee if the borrower is provided an interest rate lock-in agreement, the terms of which must include but are not limited to:

(i) the expiration date of the interest rate lock-in agreement;

(ii) the principal amount of the mortgage loan, the term of the mortgage loan, and identification of the residential real estate;

(iii) the initial interest rate and the discount points to be paid; and

(iv) the amounts and payment terms of the interest rate lock-in, along with a statement as to whether the fee is refundable and the terms and conditions necessary to obtain a refund; and

(d) a loan commitment fee, upon approval of the mortgage loan application, if the borrower is provided with a loan commitment in writing that is signed by the mortgage lender and the borrower and the terms include the terms and conditions of the mortgage loan as well as the terms and conditions of the loan commitment, including but not limited to:

(i) the time period during which the loan commitment is irrevocable and may be accepted by the borrower, which may not be less than 7 calendar days from the date of the loan commitment or the date of mailing, whichever is later;

(ii) the amount and payment terms of the loan commitment fee, along with a statement as to whether the fee is refundable and the terms and conditions necessary to obtain a refund;

(iii) the expiration date of the loan commitment;

(iv) conditions precedent to closing; and

(v) the terms and conditions, if any, for obtaining a refund of fees for third-party services or arranging for the transfer of third-party service work products to another mortgage lender.

(4) Any amount collected under subsection (3) in excess of the actual costs must be returned to the borrower within 60 days after rejection, withdrawal, or closing.

(5) (a) Except as provided in subsection (5)(b), fees or charges collected pursuant to this section, other than fees for third-party services collected pursuant to subsection (3)(a), must be refunded if a valid loan commitment is not produced or if closing does not occur.

(b) Applicable fees may be retained by the licensee in accordance with the terms of the loan commitment upon the licensee's ability to demonstrate any of the following:

(i) the borrower withdraws the mortgage loan application after the lender has issued a loan commitment on the same terms and conditions disclosed to the borrower on the most recent good faith estimate;

(ii) the borrower has made a material misrepresentation or omission on the mortgage loan application; or

(iii) the borrower has failed to provide documentation necessary to the processing or closing of the mortgage loan application and closing does not occur without fault of the lender. *(See part compiler's comment regarding contingent suspension.)*

History: **En. Sec. 24, Ch. 321, L. 2009; amd. Sec. 33, Ch. 317, L. 2011.**

32-9-149. Use of name — advertising. (1) A licensee engaged in a business regulated by this part may not operate under a name other than the name licensed by the department.

(2) A licensee may not:

(a) advertise that an applicant has unqualified access to credit without disclosing that material limitations on the availability of credit may exist, such as the percentage required as a down payment, that a higher interest rate or points could be required, or that restrictions as to the maximum principal amount of the mortgage loan offered could apply;

(b) advertise a mortgage loan with a prevailing interest rate indicated in the advertisement unless the advertisement specifically states that the interest rate could change or not be available at the time of commitment or closing;

(c) advertise mortgage loans, including interest rates, margins, discounts, points, fees, commissions, or other material information, including material limitations on the mortgage loans, unless the licensee is able to make or broker the offered mortgage loans to a reasonable number of qualified applicants;

(d) engage in false, deceptive, or misleading advertising; or

(e) falsely advertise or misuse names in violation of 18 U.S.C. 709.

(3) The department may adopt rules to define false, deceptive, or misleading advertising.

(4) In any printed, published, e-mail, or internet advertisement for the provision of services, the following information must be included:

(a) a name and unique identifier for a mortgage loan originator advertising as an individual; or

(b) the name and unique identifier only of the licensed entity when the licensed entity is advertising on its own behalf or as an entity with one or more mortgage loan originators listed.

(5) The department may adopt rules to establish requirements for licensee advertising using the internet or any electronic format.

History: En. Sec. 13, Ch. 125, L. 2013; amd. Sec. 11, Ch. 65, L. 2019.

32-9-150. Unique identifier for mortgage brokers, mortgage lenders, mortgage servicers, mortgage loan originators, and registered mortgage loan originators. (1) Each licensed mortgage broker, mortgage lender, mortgage servicer, and mortgage loan originator shall post the mortgage broker's, mortgage lender's, mortgage servicer's, or mortgage loan originator's unique identifier in a conspicuous place within the office where the licensee principally transacts business.

(2) The department shall provide a link to the consumer access portion of the NMLS on the department's website. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 28, Ch. 321, L. 2009; amd. Sec. 35, Ch. 317, L. 2011; amd. Sec. 25, Ch. 125, L. 2013.

32-9-151. Mortgage call reports. (1) Each licensee shall submit to the NMLS reports of condition, which must be in the form and must contain information that the NMLS may require.

(2) Each mortgage loan originator shall ensure that all residential mortgage loans that close as a result of the mortgage loan originator's loan origination activities are included in the report of condition submitted to the NMLS. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 29, Ch. 321, L. 2009; amd. Sec. 36, Ch. 317, L. 2011; amd. Sec. 26, Ch. 125, L. 2013.

32-9-152. Electronic record as original document. Any document or record that is required to be signed and that is filed in this state as an electronic record through the NMLS and any other electronic record filed through the NMLS must be considered a valid original document upon reproduction to paper form by the department.

History: En. Sec. 19, Ch. 125, L. 2013.

32-9-153 and 32-9-154 reserved.

32-9-155. Nationwide mortgage licensing system information challenge process. The department shall establish a process under which mortgage brokers, mortgage lenders, mortgage servicers, and mortgage loan originators may challenge information entered into the NMLS by the department. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 30, Ch. 321, L. 2009; amd. Sec. 27, Ch. 125, L. 2013.

32-9-156 through 32-9-159 reserved.

32-9-160. Confidentiality. (1) (a) Except as otherwise provided in section 1512 of the Secure and Fair Enforcement for Mortgage Licensing Act, Title V of the Housing and Economic Recovery Act of 2008, Public Law 110-289, the requirements under federal law, the Montana constitution, or Montana law regarding the privacy or confidentiality of any information or material provided to the NMLS and any privilege arising under federal or state law, including the rules of a federal or state court, pertaining to the information or material continue to apply to the information or material after the information or material has been disclosed to the NMLS.

(b) Confidential supervisory information and material may be shared with all state and federal financial services regulatory agencies and with the board of governors of the federal reserve system without the loss of confidentiality protections or the loss of privilege provided by federal law, the Montana constitution, or Montana law.

(2) The department may disclose to a licensee information about a service provider of the licensee.

(3) The department may enter into agreements or sharing arrangements with other governmental agencies, the conference of state bank supervisors, the American association of residential mortgage regulators, or associations representing governmental agencies as established by rule of the department.

(4) Information or material subject to confidentiality or a privilege under subsection (1) is not subject to:

(a) disclosure under a federal or state law governing disclosure to the public of information held by an officer or an agency of the federal government or the respective state; or

(b) subpoena, discovery, or admission into evidence in any private civil action or administrative process unless, with respect to any privilege held by the NMLS concerning the information or material, the person to whom the information or material pertains waives, in whole or in part, that privilege.

(5) Montana law relating to the disclosure of confidential supervisory information or information or material described in subsection (1) that is inconsistent with subsection (1) is superseded by the requirements of section 1512 of the Secure and Fair Enforcement for Mortgage Licensing Act, Title V of the Housing and Economic Recovery Act of 2008, Public Law 110-289.

(6) Confidential supervisory information is not subject to public inspection, subpoena, or discovery.

(7) This section does not apply to information or material relating to the employment history of and publicly adjudicated disciplinary and enforcement actions against mortgage brokers, mortgage lenders, mortgage servicers, and mortgage loan originators included in the NMLS that is available for public access. *(See part compiler's comment regarding contingent suspension.)*

History: En. Sec. 33, Ch. 321, L. 2009; amd. Sec. 37, Ch. 317, L. 2011; amd. Sec. 28, Ch. 125, L. 2013; amd. Sec. 12, Ch. 65, L. 2019; amd. Sec. 13, Ch. 4, L. 2023.

Cross-References

Right to know, Art. II, sec. 9, Mont. Const.
Right of privacy, Art. II, sec. 10, Mont. Const.
Privileges, Title 26, ch. 1, part 8.

32-9-161 through 32-9-164 reserved.

32-9-165. Types of licenses. (1) The four types of licenses under this part are mortgage broker licenses, mortgage lender licenses, mortgage servicer licenses, and mortgage loan originator licenses.

(2) A mortgage broker license may be issued to an entity that meets the requirements of 32-9-112, 32-9-113, 32-9-116, 32-9-117, 32-9-122, and 32-9-123 and employs at least one Montana-licensed mortgage loan originator.

(3) A mortgage lender license may be issued to an entity that meets the requirements of 32-9-112, 32-9-113, 32-9-116, 32-9-117, 32-9-122, and 32-9-123 and employs at least one Montana-licensed mortgage loan originator.

(4) A mortgage servicer license may be issued to an entity that meets the requirements of 32-9-112, 32-9-113, 32-9-117, and 32-9-123.

(5) A mortgage loan originator license may be issued to an individual who meets the requirements of 32-9-107, 32-9-109, 32-9-110, 32-9-112, 32-9-116, and 32-9-117 and is sponsored by a Montana-licensed mortgage broker or mortgage lender.

(6) A de novo inactive license may be issued to a mortgage loan originator that has met all the requirements for licensure except sponsorship.

(7) A de novo inactive license may be issued to an entity that has met all the requirements for licensure except employment of at least one Montana-licensed mortgage loan originator.

(8) Business may not be conducted under a de novo inactive license.

(9) A Montana-licensed entity may have one or more branch offices if the entity meets the requirements of 32-9-122 and has paid the fee required under 32-9-117.

(10) Licenses under this part may not be assigned or transferred.

History: En. Sec. 8, Ch. 317, L. 2011; amd. Sec. 29, Ch. 125, L. 2013.

32-9-166. Reports. (1) A licensee shall file a written report with the department through the NMLS within 30 business days of any material change to the information provided in a licensee's application.

(2) A licensee shall file a written report with the department within 1 business day after the licensee has reason to know of the occurrence of any of the following:

(a) the filing of a petition by or against the licensee under the United States Bankruptcy Code, 11 U.S.C. 101, et seq., for bankruptcy or reorganization;

(b) the filing of a petition by or against the licensee for receivership, the commencement of any other judicial or administrative proceeding for the licensee's dissolution or reorganization, or the making of a general assignment for the benefit of the licensee's creditors;

(c) the licensee's decision to cease doing business for any reason;

(d) the commencement of a proceeding to revoke or suspend the licensee's license in a state in which the licensee engages in business or is licensed;

(e) the cancellation or other impairment of the licensee's or an exempt company's bond; or

(f) a felony conviction of the licensee, employee of a licensee, or control person of a licensee.

(3) A licensee shall file a written report with the department through the NMLS within 15 business days after the licensee has reason to know of the occurrence of any of the following:

(a) fraud, theft, or conversion by a borrower against the licensee;

(b) fraud, theft, or conversion by a licensee;

(c) fraud, theft, or conversion by an employee or independent contractor of a licensee;

(d) violation of a provision of 32-9-124;

(e) the discharge of any employee or termination of an independent contractor for dishonest or fraudulent acts;

(f) any administrative, civil, or criminal action initiated against the licensee or any of its control persons by any government entity; or

(g) a cybersecurity incident that affects the licensee's ability to do business or involves access or potential access to a customer's personal information.

(4) (a) In the absence of malice, fraud, or bad faith, a person may not be subjected to civil liability arising from the filing of a complaint with the department or furnishing of other information required by this section or required by the department under the authority granted in this section.

(b) In the absence of malice, fraud, or bad faith, a civil cause of action of any nature may not be brought against a person for any information:

(i) relating to suspected prohibited acts and furnished to or received from law enforcement officials, their agents, or employees or furnished to or received from other regulatory or licensing authorities;

(ii) furnished to or received from other persons subject to the provisions of this part; or

(iii) furnished in complaints filed with the department.

History: En. Sec. 21, Ch. 317, L. 2011; amd. Sec. 14, Ch. 24, L. 2015; amd. Sec. 14, Ch. 4, L. 2023.

32-9-167. Change of control. (1) Without the prior approval of the department, it is unlawful for an action to be taken that results in a change of control of an entity licensed under this part. Prior to a change of control of a licensed entity, a person seeking to acquire control shall apply for an amendment to the license or a new license as required by the NMLS and pay all applicable fees.

(2) The department shall approve or disapprove the application for an amendment or new license in accordance with the provisions of this part.

History: En. Sec. 22, Ch. 317, L. 2011; amd. Sec. 30, Ch. 125, L. 2013.

32-9-168. Mortgage lender prohibitions. A mortgage lender may not:

(1) cause or require a borrower to obtain property insurance coverage in an amount that exceeds the replacement cost of the improvements as established by the property insurer;

(2) disburse the mortgage loan proceeds to a closing agent in any form other than, as applicable:

(a) direct deposit to a borrower's account;

(b) wire transfer;

(c) bank or certified check;

(d) attorney's check drawn on a trust account; or

(e) other form as specifically authorized by applicable law;

(3) disburse the proceeds of a mortgage loan without sufficient collected funds on hand at the time of the disbursement in the account upon which the funds are drawn;

(4) fail to disburse funds in accordance with a loan commitment to make a mortgage loan that was accepted by the borrower;

(5) fail to take the actions required to effect a release of the lender's security interest in the property as described in 71-1-212;

(6) advertise that a mortgage applicant will have unqualified access to credit without disclosing what material limitations on the availability of credit exist, such as the percentage of

downpayment required, that a higher rate or points could be required, or that restrictions as to the maximum principal amount of the mortgage loan offered could apply;

(7) advertise a mortgage loan for which a prevailing rate is indicated in the advertisement unless the advertisement specifically states that the expressed rate could change or not be available at commitment or closing;

(8) advertise mortgage loans, including rates, margins, discounts, points, fees, commissions, or other material information, including material limitations on mortgage loans, unless the person is able to make advertised mortgage loans to a reasonable number of qualified applicants; or

(9) falsely advertise or misuse names in violation of 18 U.S.C. 709 or 32-1-402.

History: En. Sec. 24, Ch. 317, L. 2011.

32-9-169. Mortgage servicer prohibitions. A mortgage servicer may not:

(1) fail to comply with the mortgage loan servicing transfer, escrow account administration, or borrower inquiry response requirements imposed by the Real Estate Settlement Procedures Act of 1974, 12 U.S.C. 2601, et seq., and regulations adopted under that act;

(2) fail to comply with applicable state and federal laws, rules, and regulations related to mortgage servicing;

(3) fail to provide written notice to a borrower upon taking action to place hazard, homeowner's, or flood insurance on the mortgaged property or to place the insurance when the mortgage servicer knows or has reason to know that there is insurance in effect;

(4) place hazard, homeowner's, or flood insurance on a mortgaged property for an amount that exceeds either the value of the insurable improvements or the last-known coverage amount of insurance;

(5) fail to provide to the borrower a refund of unearned premiums paid by a borrower or charged to the borrower for hazard, homeowner's, or flood insurance placed by a mortgage lender or mortgage servicer if the borrower provides reasonable proof that the borrower has obtained coverage so that the forced placement is no longer necessary and the property is insured. If the borrower provides reasonable proof within 12 months of the placement that no lapse in coverage occurred so that the forced placement was not necessary, the mortgage servicer shall refund the entire premium.

(6) fail to make all payments from any escrow account held for the borrower for insurance, taxes, and other charges with respect to the property in a timely manner so as to ensure that late penalties are not assessed or other negative consequences do not result regardless of whether the loan is delinquent unless there are not sufficient funds in the account to cover the payments and the mortgage servicer has a reasonable basis to believe that recovery of the funds will not be possible.

History: En. Sec. 25, Ch. 317, L. 2011; amd. Sec. 15, Ch. 24, L. 2015; amd. Sec. 13, Ch. 275, L. 2017.

32-9-170. Mortgage servicer duties. In addition to any duties imposed by federal law or regulations or the common law, a mortgage servicer shall:

(1) safeguard and account for any money handled for the borrower;

(2) follow reasonable and lawful instructions from the borrower;

(3) act with reasonable skill, care, and diligence;

(4) comply with the servicing standards set by the department by rule;

(5) file with the department a complete, current schedule of the ranges of costs and fees the mortgage servicer charges borrowers for servicing-related activities with the mortgage servicer's application and with any supplemental filings made as often as the schedule of costs and fees is amended;

(6) file with the department upon request a report in a form and format set forth by the department by rule detailing the mortgage servicer's activities in this state;

(7) at the time the mortgage servicer accepts assignment of servicing rights for a mortgage loan, disclose any notice required under federal law or regulation; and

(8) in the event of a delinquency or other act of default on the part of the borrower, act in good faith to inform the borrower of the facts concerning the loan and the nature and extent of the delinquency or default and, if the borrower replies, negotiate with the borrower, subject to

the mortgage servicer's duties and obligations under the mortgage servicing contract, if any, to attempt a resolution or workout pertaining to the delinquency or default.

History: En. Sec. 34, Ch. 317, L. 2011; amd. Sec. 31, Ch. 125, L. 2013; amd. Sec. 16, Ch. 24, L. 2015; amd. Sec. 13, Ch. 65, L. 2019.

32-9-171. Repealed. Sec. 15, Ch. 4, L. 2023.

History: En. Sec. 1, Ch. 65, L. 2019.

32-9-172. Mortgage lender net worth requirement. (1) A mortgage lender shall continuously maintain the minimum net worth required by this section.

(2) A mortgage lender must have a minimum net worth of $250,000 and submit evidence that establishes compliance with this section. Evidence of net worth must include submission of recent financial statements accompanied by a written statement by an independent certified public accountant attesting that the accountant has reviewed the financial statements in accordance with generally accepted accounting principles.

(3) If the net worth of a mortgage lender falls below the minimum net worth set forth in subsection (2), the licensee shall provide a plan, subject to approval of the department, to increase the licensee's net worth to an amount in conformance with this section. Submission of a plan under this section must be made within 30 business days of service of a notice from the department that the licensee is not in compliance with subsection (2). A plan that is not timely submitted or that is not approved by the department may result in denial of the application, issuance of a cease and desist order, license suspension, or license revocation.

(4) Maintenance of the minimum net worth specified under this section is a requirement for continued licensure. Failure to meet or maintain the minimum net worth standards under this part may constitute grounds for the denial of an application, issuance of a cease and desist order, license suspension, or license revocation.

History: En. Sec. 2, Ch. 65, L. 2019.

32-9-173. Requirements for remote work. (1) Mortgage business may be conducted at a remote work location if:

(a) the licensed mortgage entity's employees and independent contractors do not meet with the public at an unlicensed personal residence;

(b) no physical or electronic business records are maintained at the remote location;

(c) the licensed mortgage entity has written policies and procedures for working remotely and the entity supervises and enforces the policies and procedures;

(d) no signage or advertising of the entity or the mortgage loan originator is displayed at any remote work location;

(e) the licensed mortgage entity maintains the computer system and customer information in accordance with the entity's information technology security plan and all state and federal laws;

(f) any device used to engage in mortgage business has appropriate security, encryption, and device management controls to ensure the security and confidentiality of customer information as required by rules and regulations adopted by the department;

(g) the licensed mortgage entity's employees and independent contractors take reasonable precautions to protect confidential information in accordance with state and federal laws;

(h) the NMLS record of a mortgage loan originator that works remotely designates a properly licensed location as the mortgage loan originator's official workstation and a designated manager as a supervisor; and

(i) the licensed mortgage entity annually reviews and certifies that the employees and independent contractors engaged in mortgage business at a remote location meet the requirements of this section. Upon request, a licensee shall provide written documentation of the licensee's review to the department.

(2) If the commissioner determines that the licensee does not provide reasonable and adequate supervision of the employee, the commissioner shall notify the licensee in writing and within 5 business days of receiving the notice the licensee shall terminate the employee's eligibility to work remotely as provided under this section.

(3) The department shall adopt rules to implement this section.

History: En. Sec. 7, Ch. 4, L. 2023.

Part 2
Nonbank Mortgage Servicers

32-9-201. Definitions. As used in this part, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Allowable assets for liquidity" means those assets that may be used to satisfy the liquidity requirements in this part, including unrestricted cash and cash equivalents and unencumbered investment grade assets held for sale or trade.

(2) "Corporate governance" means the structure of an institution and how it is managed, including the corporate rules, policies, processes, and practices used to oversee and manage the institution.

(3) "Covered institution" means a nonbank servicer:

(a) with servicing portfolios of 2,000 or more 1- to 4-unit residential mortgage loans serviced or subserviced for others, excluding whole loans owned, and loans being interim serviced prior to sale as of the most recent calendar year end, reported in the NMLS mortgage call report; and

(b) that operates in two or more states, districts, or territories of the United States either currently or as of the prior calendar year end.

(4) "Department" means the department of administration provided for in 2-15-1001, acting through its division of banking and financial institutions.

(5) "External audit" means the formal report prepared by an independent certified public accountant expressing an opinion on whether the financial statements are presented fairly in all material aspects in accordance with the applicable financial reporting framework, and is inclusive of an evaluation of the adequacy of a company's internal control structure.

(6) "GSE" means government-sponsored enterprises, the federal national mortgage association, or the federal home loan mortgage corporation.

(7) "Interim serviced prior to sale" means the activity of collecting a limited number of contractual mortgage payments immediately after origination on loans held for sale but prior to the loans being sold into the secondary market.

(8) "Internal audit" means the internal activity of performing independent, objective assurance and consulting to evaluate and improve the effectiveness of company operations, risk management, internal controls, and governance processes.

(9) "Licensee" has the same meaning as provided in 32-9-103.

(10) "Mortgage" has the same meaning as provided in 32-9-103.

(11) "Mortgage call report" means the quarterly or annual report of residential real estate loan origination, servicing, and financial information completed by companies licensed in NMLS.

(12) "Mortgage servicing rights" means the contractual right to service residential mortgage loans on behalf of the owner of the associated mortgage in exchange for specified compensation in accordance with the servicing contract.

(13) "Mortgage servicing rights investor" means entities that invest in and own mortgage servicing rights and rely on subservicers to administer the loans on their behalf.

(14) "Mortgage-backed security" means financial instruments, often debt securities, collateralized by residential mortgages.

(15) "Operating liquidity" means the funds necessary to perform normal business operations, such as payment of rent, salaries, interest expense, and other typical expenses associated with operating the entity.

(16) "Residential mortgage loan" means a loan primarily for personal, family, or household use secured by a mortgage, deed of trust, or other equivalent consensual security interest on a dwelling or on residential real estate located in Montana.

(17) "Residential mortgage loans serviced" means the specific portfolio or portfolios of residential mortgage loans for which a licensee is contractually responsible to the owner or owners of the mortgage loans for the defined servicing activities.

(18) "Reverse mortgage" means a loan collateralized by real estate, typically made to borrowers over 55 years of age, that does not require contractual monthly payments and is typically repaid upon the death of the borrower through the sale of the home or refinance by the heirs.

(19) "Risk management" means the policies and procedures designed to identify, measure, monitor, and mitigate risk sufficient for the level of sophistication of the servicer.

(20) "Servicer" means the entity performing the routine administration of residential mortgage loans on behalf of the owner or owners of the related mortgages under the terms of a servicing contract.

(21) "Servicing liquidity" or "liquidity" means the financial resources necessary to manage liquidity risk arising from servicing functions required in acquiring and financing mortgage servicing rights, hedging costs, including margin calls, associated with the mortgage servicing rights asset and financing facilities, and advances or costs of advance financing for principal, interest, taxes, insurance, and any other servicing related advances.

(22) "Subservicer" means the entity performing the routine administration of residential mortgage loans as agent of a servicer or under the terms of a subservicing contract.

(23) "Subservicing for others" means the contractual activities performed by subservicers on behalf of a servicer or mortgage servicing rights investor.

(24) "Unencumbered investment grade assets held for sale or trade" means agency mortgage-backed securities, obligations of GSEs, and U.S. treasury obligations.

(25) "Whole loans" mean those loans for which a mortgage and the underlying credit risk is owned and held on balance sheet of the entity with all ownership rights.

History: En. Sec. 1, Ch. 4, L. 2023.

32-9-202. Applicability — exclusions. (1) This part is applicable to covered institutions. For entities within a holding company or affiliated group of companies, applicability is at the covered institution level.

(2) The following exclusions apply:

(a) This part does not apply to not-for-profit servicers or housing finance agencies.

(b) Section 32-9-206 does not apply to servicers solely owning or conducting reverse mortgage servicing, or the reverse mortgage portfolio administered by covered institutions or the whole loan portion of portfolios.

(c) A servicer with 25 or fewer loans, a servicer that is wholly owned and controlled by one or more depository institutions regulated by a state or federal banking agency, or a servicer that is also licensed as an escrow business may apply to the department to waive or adjust one or more of the financial condition requirements in 32-9-206. In considering such a request, the department shall consider whether the servicer has a positive net worth and adequate operating reserves.

History: En. Sec. 2, Ch. 4, L. 2023.

32-9-203 through 32-9-205 reserved.

32-9-206. Financial condition of servicers. (1) A covered institution shall maintain capital and liquidity in compliance with this section.

(2) For the purposes of complying with the capital and liquidity requirements of this section, all financial data must be determined in accordance with generally accepted accounting principles.

(3) A covered institution that meets the federal housing finance agency eligibility requirements for enterprise single-family seller/servicers for capital, net worth ratio, and liquidity, regardless of whether the servicer is approved for GSE servicing, meets the requirements of subsections (1) and (2).

(4) Covered institutions shall maintain written policies and procedures implementing the capital and servicing liquidity requirements as set by the department by rule.

(5) Covered institutions shall maintain sufficient allowable assets for liquidity, in addition to the amounts required for servicing liquidity, to cover normal business operations.

(6) Covered institutions shall have in place sound cash management and business operating plans as set by the department by rule.

(7) Covered institutions shall develop, establish, and implement plans, policies, and procedures for maintaining operating liquidity sufficient for the ongoing needs of the institution. The department shall set further requirements for operating liquidity by rule.

History: En. Sec. 3, Ch. 4, L. 2023.

32-9-207. Corporate governance of servicers. Covered institutions shall establish and maintain corporate governance standards as set by the department by rule. The standards must include internal and external audits and risk management.

History: En. Sec. 4, Ch. 4, L. 2023.

32-9-208. Authority of department regarding servicers. (1) If risk is determined by a formal review of a specific covered institution to be extremely high, the department may order or direct the institution to satisfy additional conditions necessary to ensure that the institution will continue to operate in a safe and sound manner and be able to continue to service loans in compliance with state and federal law and regulation.

(2) If risk is determined by a formal review of a specific covered institution or institutions to be extremely low, the department may provide notice to the institution or institutions that all or part of this part is not applicable to those covered institutions.

(3) Whenever economic, environmental, or societal events are determined to be of such severity to warrant a temporary suspension of all or certain sections of this part, the department may provide public notice by proclamation of a temporary suspension.

History: En. Sec. 5, Ch. 4, L. 2023.

32-9-209. Rulemaking. The department shall adopt rules necessary to carry out the intent and purposes of this part. In adopting rules under this part, the department shall use the final model state regulatory prudential standards for nonbank mortgage servicers in effect at the time of rulemaking as published by the conference of state bank supervisors.

History: En. Sec. 6, Ch. 4, L. 2023.

CHAPTER 10
MONTANA RESIDENTIAL MORTGAGE LENDER LICENSING ACT
(Repealed)

Part 1 — General Provisions (Repealed)
Part 2 — Licensing (Repealed)
Part 3 — Regulation of Licensees (Repealed)
Part 4 — Violations (Repealed)
Part 5 — Enforcement (Repealed)

Part 1
General Provisions
(Repealed)

32-10-101. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 1, Ch. 369, L. 2007.

32-10-102. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 2, Ch. 369, L. 2007.

32-10-103. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 3, Ch. 369, L. 2007.

Part 2
Licensing
(Repealed)

32-10-201. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 4, Ch. 369, L. 2007.

32-10-202. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 5, Ch. 369, L. 2007.

32-10-203. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 6, Ch. 369, L. 2007.

32-10-204. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 7, Ch. 369, L. 2007.

32-10-205 and 32-10-206 reserved.

32-10-207. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 8, Ch. 369, L. 2007.

32-10-208. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 9, Ch. 369, L. 2007.

32-10-209. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 10, Ch. 369, L. 2007.

Part 3
Regulation of Licensees
(Repealed)

32-10-301. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 11, Ch. 369, L. 2007.

32-10-302. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 12, Ch. 369, L. 2007.

32-10-303. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 13, Ch. 369, L. 2007.

32-10-304 through 32-10-308 reserved.

32-10-309. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 14, Ch. 369, L. 2007.

32-10-310. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 15, Ch. 369, L. 2007.

Part 4
Violations
(Repealed)

32-10-401. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 16, Ch. 369, L. 2007.

32-10-402. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 17, Ch. 369, L. 2007.

32-10-403. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 18, Ch. 369, L. 2007.

32-10-404. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 19, Ch. 369, L. 2007.

32-10-405. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 20, Ch. 369, L. 2007.

32-10-406. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 21, Ch. 369, L. 2007.

Part 5
Enforcement
(Repealed)

32-10-501. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 22, Ch. 369, L. 2007.

32-10-502. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 23, Ch. 369, L. 2007.

32-10-503. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 24, Ch. 369, L. 2007.

32-10-504. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 25, Ch. 369, L. 2007.

32-10-505. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 26, Ch. 369, L. 2007.

32-10-506. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 27, Ch. 369, L. 2007.

32-10-507. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 28, Ch. 369, L. 2007.

32-10-508 through 32-10-511 reserved.

32-10-512. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 29, Ch. 369, L. 2007.

32-10-513. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 30, Ch. 369, L. 2007.

32-10-514. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 31, Ch. 369, L. 2007.

32-10-515. Repealed. Sec. 34, Ch. 321, L. 2009.
History: En. Sec. 32, Ch. 369, L. 2007.

CHAPTER 11

BUSINESS AND INDUSTRIAL DEVELOPMENT CORPORATIONS (Repealed)

Part 1 — General Procedures — Definitions — Purposes (Repealed)

Part 2 — Licensure Procedures — Board of Directors (Repealed)

Part 3 — Acquisition and Merger (Repealed)

Part 4 — Investigations and Penalties (Repealed)

Part 1

General Procedures — Definitions — Purposes (Repealed)

32-11-101. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 1, Ch. 411, L. 2007.

32-11-102. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 2, Ch. 411, L. 2007.

32-11-103. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 3, Ch. 411, L. 2007.

32-11-104. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 48, Ch. 411, L. 2007.

32-11-105. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 4, Ch. 411, L. 2007.

32-11-106. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 55, Ch. 411, L. 2007.

32-11-107. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 56, Ch. 411, L. 2007; amd. Sec. 51, Ch. 348, L. 2015.

32-11-108. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 52, Ch. 411, L. 2007.

Part 2
Licensure Procedures — Board of Directors (Repealed)

32-11-201. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 5, Ch. 411, L. 2007.

32-11-202. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 6, Ch. 411, L. 2007.

32-11-203. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 31, Ch. 411, L. 2007.

32-11-204. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 7, Ch. 411, L. 2007.

32-11-205. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 8, Ch. 411, L. 2007.

32-11-206. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 9, Ch. 411, L. 2007.

32-11-207. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 10, Ch. 411, L. 2007.

32-11-208. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 11, Ch. 411, L. 2007.

32-11-209. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 12, Ch. 411, L. 2007.

32-11-210. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 15, Ch. 411, L. 2007.

32-11-211. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 16, Ch. 411, L. 2007.

32-11-212. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 17, Ch. 411, L. 2007.

32-11-213 and 32-11-214 reserved.

32-11-215. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 13, Ch. 411, L. 2007.

32-11-216. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 14, Ch. 411, L. 2007.

32-11-217. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 18, Ch. 411, L. 2007.

32-11-218. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 19, Ch. 411, L. 2007.

32-11-219. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 20, Ch. 411, L. 2007.

32-11-220. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 21, Ch. 411, L. 2007.

32-11-221. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 22, Ch. 411, L. 2007.

32-11-222. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 23, Ch. 411, L. 2007.

32-11-223. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 24, Ch. 411, L. 2007.

32-11-224. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 25, Ch. 411, L. 2007.

32-11-225. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 26, Ch. 411, L. 2007.

32-11-226. Repealed. Sec. 1, Ch. 13, L. 2023.
History: En. Sec. 54, Ch. 411, L. 2007.

Part 3
Acquisition and Merger (Repealed)

32-11-301. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 27, Ch. 411, L. 2007.

32-11-302. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 28, Ch. 411, L. 2007.

32-11-303. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 29, Ch. 411, L. 2007.

32-11-304. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 32, Ch. 411, L. 2007.

32-11-305. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 33, Ch. 411, L. 2007.

32-11-306. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 34, Ch. 411, L. 2007; amd. Sec. 1, Ch. 5, L. 2017; amd. Sec. 64, Ch. 261, L. 2021.

32-11-307. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 35, Ch. 411, L. 2007.

32-11-308. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 36, Ch. 411, L. 2007.

32-11-309. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 37, Ch. 411, L. 2007.

32-11-310. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 38, Ch. 411, L. 2007.

32-11-311. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 39, Ch. 411, L. 2007.

32-11-312. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 53, Ch. 411, L. 2007.

32-11-313. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 40, Ch. 411, L. 2007.

Part 4
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32-11-401. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 30, Ch. 411, L. 2007.

32-11-402. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 41, Ch. 411, L. 2007.

32-11-403. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 42, Ch. 411, L. 2007.

32-11-404. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 43, Ch. 411, L. 2007.

32-11-405. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 44, Ch. 411, L. 2007.

32-11-406. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 45, Ch. 411, L. 2007.

32-11-407. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 46, Ch. 411, L. 2007.

32-11-408 through 32-11-410 reserved.

32-11-411. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 47, Ch. 411, L. 2007.

32-11-412. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 49, Ch. 411, L. 2007.

32-11-413. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 50, Ch. 411, L. 2007.

32-11-414. Repealed. Sec. 2, Ch. 13, L. 2023.
History: En. Sec. 51, Ch. 411, L. 2007.

TITLE 33

INSURANCE AND INSURANCE COMPANIES

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CHAPTER 1

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Part 1
General Provisions

33-1-101. Short title. This title constitutes the "Montana Insurance Code".
History: En. Sec. 1, Ch. 286, L. 1959; R.C.M. 1947, 40-2601; amd. Sec. 1, Ch. 77, L. 1979.

33-1-102. Compliance required — exceptions — health service corporations — health maintenance organizations — governmental insurance programs — service contracts. (1) A person may not transact a business of insurance in Montana or a business relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) The provisions of this code do not apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6;

(c) fraternal benefit societies, except as stated in chapter 7; and

(d) direct agreements between a health care provider or health care facility as defined in 50-12-102 and a patient for the provision of an experimental treatment or services related to the provision of an experimental treatment.

(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of those organizations are governed by chapter 31.

(5) This code does not apply to workers' compensation insurance programs provided for in Title 39, chapter 71, part 21, and related sections.

(6) The department of public health and human services may limit the amount, scope, and duration of services for programs established under Title 53 that are provided under contract by entities subject to this title. The department of public health and human services may establish more restrictive eligibility requirements and fewer services than may be required by this title.

(7) This code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8, or the Montana university system group benefits plans established in Title 20, chapter 25, part 13.

(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided for in 2-9-202.

(9) (a) Except as otherwise provided in Title 33, chapters 22 and 28, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention, deductible, or self-insurance plan.

(b) Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan, or program of a single political subdivision of this state in which the political subdivision provides to its officers, elected officials, or employees disability insurance or life insurance through a self-funded program.

(10) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making of, proposal to make, and administration of a service contract governed by Title 30, chapter 14, part 13.

(11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for the financial risk under the contract with the third party as provided in 7-34-103.

(b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or town, the entity is subject to the provisions of this code.

(12) This code does not apply to the self-insured student health plan established in Title 20, chapter 25, part 14.

(13) Except as provided in 33-2-2212, this code does not apply to private air ambulance services that are in compliance with 50-6-320 and that solicit membership subscriptions, accept membership applications, charge membership fees, and provide air ambulance services to subscription members and designated members of their households.

(14) This code does not apply to guaranteed asset protection waivers that are governed by Title 30, chapter 14, part 22, or to vehicle theft protection products or vehicle theft protection product warranties that are governed by Title 30, chapter 14, part 13.

(15) This code does not apply to direct patient care agreements established pursuant to 50-4-107.

(16) This code does not apply to a health care sharing ministry that meets the requirements of 50-4-111.

(17) This code does not apply to a regulatory sandbox waiver, except as otherwise specified by the commissioner or as provided in 33-2-2501. *(Subsection (17) terminates July 30, 2029—sec. 5, Ch. 546, L. 2023.)*

History: En. Sec. 9, Ch. 286, L. 1959; Sec. 40-2609, R.C.M. 1947; (2)En. Sec. 10, Ch. 286, L. 1959; Sec. 40-2610, R.C.M. 1947; (3)En. Sec. 11, Ch. 286, L. 1959; Sec. 40-2611, R.C.M. 1947; R.C.M. 1947, 40-2609, 40-2610, 40-2611; amd. Sec. 31, Ch. 457, L. 1987; amd. Sec. 1, Ch. 502, L. 1987; amd. Sec. 1, Ch. 558, L. 1987; amd. Sec. 52, Ch. 613, L. 1989; amd. Sec. 22, Ch. 4, Sp. L. May 1990; amd. Sec. 2, Ch. 727, L. 1991; amd. Sec. 12, Ch. 502, L. 1995; amd. Sec. 1, Ch. 590, L. 1995; amd. Sec. 1, Ch. 577, L. 1999; amd. Sec. 2, Ch. 13, L. 2001; amd. Sec. 8, Ch. 227, L. 2001; amd. Sec. 2, Ch. 359, L. 2009; amd. Sec. 2, Ch. 54, L. 2011; amd. Sec. 4, Ch. 199, L. 2011; amd. Sec. 2, Ch. 237, L. 2011; amd. Sec. 3, Ch. 351, L. 2011; amd. Sec. 8, Ch. 313, L. 2013; amd. Sec. 8, Ch. 363, L. 2013; amd. Sec. 1, Ch. 229, L. 2015; amd. Sec. 5, Ch. 320, L. 2015; amd. Sec. 10, Ch. 210, L. 2017; amd. Sec. 6, Ch. 262, L. 2021; amd. Sec. 2, Ch. 422, L. 2021; amd. Sec. 5, Ch. 525, L. 2023; amd. Sec. 2, Ch. 546, L. 2023; amd. Sec. 4, Ch. 621, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 4, Ch. 621, L. 2025. Amendment effective May 13, 2025.

Cross-References

Securities registration — exemption, 30-10-104, 33-10-105.
Common trust funds — exclusion, 32-1-708.
Consumer loan businesses — insurance requirements, 32-5-306.
License required of health service corporations, 33-30-108.

33-1-103. Particular provisions prevail. Provisions of this code relative to a particular kind of insurance or a particular type of insurer or to a particular matter shall prevail over provisions relating to insurance in general or insurers in general or to such matter in general.

History: En. Sec. 16, Ch. 286, L. 1959; R.C.M. 1947, 40-2616.

Cross-References

Particular laws qualify general, 1-3-225.

33-1-104. Repealed. Sec. 32, Ch. 396, L. 2017.

History: En. Sec. 17, Ch. 286, L. 1959; R.C.M. 1947, 40-2617; amd. Sec. 79, Ch. 370, L. 1987; amd. Sec. 5, Ch. 606, L. 1987.

33-1-105 and 33-1-106 reserved.

33-1-107. Repealed. Sec. 12, Ch. 456, L. 2005.

History: En. Sec. 1, Ch. 227, L. 2001.

33-1-108 and 33-1-109 reserved.

33-1-110. Limitations of provider agreements. (1) Notwithstanding any other provision of law, a provider who has entered into a provider agreement with a person as defined in 33-1-202 is not required to provide a discount or accept payment at the rate agreed to in the provider agreement for health care services that are provided to an insured individual if the payment for the services is made directly or indirectly or is otherwise required to be made:

(a) under casualty insurance as described in 33-1-206; or

(b) under property insurance as described in 33-1-210.

(2) Insurance payments made to a provider of health care services under subsection (1) must be paid according to the terms of the applicable policy or in accordance with any written agreement or contract existing between the provider and the insurer or a person contractually engaged by the insurer to perform services or an insurance function for the insurer. This section does not prohibit negotiations regarding the amount of the billed charges or a reasonable request for additional information or documents in order to evaluate the claim.

(3) An insurer making payment on a claim under a disability insurance policy, member contract, health benefit plan, group health plan, blanket disability insurance policy as defined in 33-22-601, or other medical coverage shall credit toward satisfaction of the insured's deductible, copayment, or coinsurance, if any, any payment made by a casualty or property insurer but only if the payment to be credited is applied to a covered medical expense under the terms of the applicable health policy.

(4) The provisions of this section apply regardless of whether the insured may be considered a third-party beneficiary of the provider agreement.

History: **En. Sec. 1, Ch. 420, L. 2013.**

33-1-111. Eligibility requirements of health insurance issuers. (1) As a condition of doing business in the state of Montana, a health insurance issuer, a multiple employer welfare arrangement, a third-party administrator, a health maintenance organization, a pharmacy benefit manager, a health services corporation, or any other party that by statute, contract, or agreement is legally responsible for payment of a claim for a health care item or service shall:

(a) upon request, provide to the department of public health and human services eligibility information for individuals who are eligible for or receiving medicaid, including but not limited to:

(i) data to determine during what period the medicaid recipient or medicaid-eligible individual or the spouse or dependents of the recipient or eligible individual may be or may have been covered by any of the entities listed in this section; and

(ii) data regarding the nature of the coverage that is or was provided, including but not limited to the name, address, and identifying information of the entity providing coverage;

(b) respond to any inquiry from the department of public health and human services regarding a claim for payment for any health care item or service submitted not later than 3 years after the date the item or service was provided;

(c) accept the department of public health and human services' right of recovery and the assignment from the medicaid recipient to the department of public health and human services of any right of an individual or other entity to payment from any of the entities listed in this section for an item or service for which medicaid has paid; and

(d) agree not to deny a claim submitted by the department of public health and human services solely on the basis of the date of submission of the claim, the type or format of the claim form, the failure to obtain prior authorization for the item or service pursuant to the third party payer's rules, or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(i) the claim is submitted by the department of public health and human services within the 3-year period beginning on the date on which the service or item was provided; and

(ii) any action by the department of public health and human services to enforce its rights with respect to the claim is commenced within 6 years after the department submitted the claim.

(2) This section may not be construed to:

(a) require that a third party pay any claim by the department of public health and human services for services or items that are not covered under the applicable health care plan;

(b) require that any third-party administrator, fiscal intermediary, or other contractor pay a claim by the department of public health and human services from its own funds unless the entity also bears the financial obligation for the claim under the applicable plan documents;

(c) impose any liability on an entity to pay claims that the entity does not otherwise bear; or

(d) negate any right of indemnification against a plan sponsor or other entity with ultimate liability for health care claims by a third-party administrator, fiscal intermediary, or other contractor that pays the claims.

History: **En. Sec. 1, Ch. 249, L. 2007; amd. Sec. 53, Ch. 2, L. 2009; amd. Sec. 1, Ch. 138, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 1, Ch. 138, L. 2025. Amendment effective October 1, 2025.

33-1-112 through 33-1-114 reserved.

33-1-115. Operation of state fund as authorized insurer — issuance of certificate of authority — exceptions — use of calendar year — risk-based capital — reporting requirements. (1) The state fund provided for in 39-71-2313 is an authorized insurer and, except as provided in this section, is subject to the provisions in Title 33 that are generally applicable to authorized workers' compensation insurers in this state and the provisions of Title 39, chapter 71, part 23.

(2) (a) The commissioner shall issue a certificate of authority to the state fund to write workers' compensation insurance coverages, as provided in 39-71-2316, and except as otherwise provided in this section the requirements of Title 33, chapter 2, part 1, do not apply. The certificate of authority must be continuously renewed by the commissioner.

(b) The state fund shall pay the annual fee under 33-2-708, provide the surplus funds required under 33-2-109 and 33-2-110, and provide to the commissioner the available documentation and information that is provided by other insurers when applying for a certificate of authority under 33-2-115.

(c) The state fund is subject to the reporting requirements under 33-2-705 but is not subject to the tax on net premiums.

(3) (a) The state fund, as the guaranteed market for workers' compensation insurance for employers pursuant to 39-71-2313, is not subject to:

(i) formation requirements of an insurer under Title 33, chapter 3;

(ii) revocation or suspension of its certificate of authority under any provision of Title 33 or any order or any provision that requires forfeiture of the state fund's obligation to insure employers as required in 39-71-2313;

(iii) liquidation or dissolution under Title 33;

(iv) participation in the guaranty association provided for in Title 33, chapter 10;

(v) 33-12-104; or

(vi) any assessment of punitive or exemplary damages.

(b) The state fund is subject to 33-16-1023, except as provided in 39-71-2316(1)(e), (1)(f), and (1)(g).

(4) The state fund shall complete financial reporting and accounting on a calendar year basis.

(5) (a) If the state fund's risk-based capital falls below the company action level RBC as defined in 33-2-1902, the commissioner shall issue a report to the governor, the state fund board of directors, and to the legislature in accordance with 5-11-210. If the legislature is not in session, the report must go to the economic affairs interim committee in accordance with 5-11-210 and to the legislative auditor. The report must provide a description of the RBC measurement, the regulatory implications of the state fund falling below the RBC criteria, and the state fund's corrective action plan. If the commissioner is reporting on a regulatory action level RBC event, the report must include the state fund's corrective action plan, results of any examination or analysis by the commissioner, and any corrective orders issued by the commissioner.

(b) If the state fund fails to comply with any lawful order of the commissioner, the commissioner may initiate supervision proceedings under Title 33, chapter 2, part 13, against state fund. If the state fund fails to comply with the commissioner's lawful supervision order under this subsection (5)(b), the commissioner may institute rehabilitation proceedings under Title 33, chapter 2, part 13, only if the commissioner is petitioning for rehabilitation based on the grounds provided in 33-2-1321(1) or (2).

(6) The state fund shall annually transfer funds to the commissioner, out of its surplus, for all necessary staffing and related expenses for a full-time attorney licensed to practice law in Montana and a full-time examiner qualified by education, training, experience, and high professional competence to examine the state fund pursuant to Title 33, chapter 1, part 4, and this section. The attorney and examiner must be employees of the commissioner.

(7) For the purposes of this section, the term "guaranteed market" has the definition provided in 39-71-2312.

History: En. Sec. 1, Ch. 320, L. 2015; amd. Sec. 65, Ch. 261, L. 2021.

Part 2
Definitions and Insurance Coverages

33-1-201. Definitions — insurance in general — general terms. For the purposes of this code, the following definitions apply unless the context requires otherwise:

(1) "Alien insurer" is an insurer formed under the laws of any country other than the United States or its states, districts, territories, and commonwealths.

(2) "Authorized insurer" is an insurer duly authorized by a certificate of authority issued by the commissioner to transact insurance in this state.

(3) "Domestic insurer" is an insurer incorporated under the laws of this state.

(4) "Female" has the meaning provided in 1-1-201.

(5) "Foreign insurer" is an insurer formed under the laws of any jurisdiction other than this state. Except when distinguished by context, the term includes an alien insurer.

(6) (a) "Insurance" is a contract through which one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies.

(b) The term does not include:

(i) contracts for the installation, maintenance, and provision of inside telecommunications wiring to residential or business premises;

(ii) direct patient care agreements established pursuant to 50-4-107; or

(iii) an arrangement with a health care sharing ministry that meets the requirements of 50-4-111.

(7) (a) "Insurer" includes every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance. The term also includes a health service corporation in the provisions listed in 33-30-102.

(b) The term does not include a health care sharing ministry that meets the requirements of 50-4-111.

(8) "Male" has the meaning provided in 1-1-201.

(9) "Resident domestic insurer" is an insurer incorporated under the laws of this state and:

(a) if a mutual company, not less than one-half of the policyholders are individuals who are residents of this state; or

(b) if a stock insurer, not less than one-half of the shares are owned by individuals who are residents of this state and all of the directors and officers of the insurer are residents of this state.

(10) "Sex" has the meaning provided in 1-1-201.

(11) "State", when used in relation to jurisdiction, means a state, the District of Columbia, or a territory, commonwealth, or possession of the United States.

(12) "Transact", with respect to insurance, means to:

(a) solicit;

(b) negotiate;

(c) sell or effectuate a contract of insurance; or

(d) transact matters subsequent to effectuation of the contract of insurance and arising out of it.

(13) "Unauthorized insurer" is an insurer not authorized by a certificate of authority issued by the commissioner to transact insurance in this state.

History: En. Secs. 2, 3, 6, 7, 8, Ch. 286, L. 1959; R.C.M. 1947, 40-2602, 40-2603, 40-2606, 40-2607, 40-2608; amd. Sec. 1, Ch. 198, L. 1979; amd. Sec. 4, Ch. 664, L. 1979; amd. Sec. 1, Ch. 202, L. 1983; amd. Sec. 2, Ch. 558, L. 1987; amd. Sec. 1, Ch. 341, L. 1989; amd. Sec. 1, Ch. 399, L. 2007; amd. Sec. 7, Ch. 262, L. 2021; amd. Sec. 3, Ch. 422, L. 2021; amd. Sec. 13, Ch. 685, L. 2023.

Cross-References

Certificate of authority, Title 33, ch. 2, part 1.

33-1-202. Definitions — entities. For the purposes of this code, the following definitions apply unless the context requires otherwise:

(1) "Commissioner" means the commissioner of insurance of the state of Montana.

(2) "Department" means the department of insurance of the state of Montana.

(3) "Person" includes an individual, insurer, company, association, organization, Lloyd's, society, reciprocal or interinsurance exchange, partnership, syndicate, business trust, corporation, or any other legal entity.

(4) "Resident of this state" means a person who has maintained a principal residence within the state of Montana for a period of not less than 2 consecutive years.

History: En. Secs. 4, 5, Ch. 286, L. 1959; R.C.M. 1947, 40-2604, 40-2605; amd. Sec. 2, Ch. 198, L. 1979; amd. Sec. 2, Ch. 202, L. 1983.

Cross-References

Residence — rules for determining, 1-1-215.
Insurance Department, 2-15-1902.
Commissioner of Insurance — State Auditor as ex officio, 2-15-1903.

33-1-203 and 33-1-204 reserved.

33-1-205. Definitions of kinds of insurance not mutually exclusive. It is intended that certain insurance coverages may come within the definitions of two or more kinds of insurance as defined in this part, and the inclusion of such coverage within one definition shall not exclude it as to any other kind of insurance within the definition of which such coverage may likewise be reasonably included.

History: En. Sec. 72, Ch. 286, L. 1959; R.C.M. 1947, 40-2901.

Cross-References

Combinations of insuring powers — authority, 33-2-108.
Issuance or refusal of certificate of authority, 33-2-116.

33-1-206. Casualty insurance. (1) Casualty insurance includes:

(a) vehicle insurance, which is insurance against loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained in or on or being loaded or unloaded in or from a land vehicle, aircraft, or animal from any hazard or cause and against any loss, liability, or expense resulting from or incidental to ownership, maintenance, or use of any land vehicle, aircraft, or animal, together with insurance against accidental death or accidental injury to individuals, including the named insured, while in, entering, alighting from, adjusting, or repairing or when caused by being struck by a land vehicle, aircraft, or draft or riding animal, if the insurance is issued as an incidental part of insurance on the land vehicle, aircraft, or draft or riding animal;

(b) liability insurance, which is insurance against legal liability for the death, injury, or disability of any human being or for damage to property and the provision of medical, hospital, surgical, and disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries, or personal representatives of persons killed, irrespective of legal liability of the insured, when issued as an incidental coverage with or supplemental to liability insurance;

(c) workers' compensation and employer's liability, which is insurance of the obligations accepted by, imposed upon, or assumed by employers under law for death, disablement, or injury of employees;

(d) (i) burglary and theft, which is insurance against loss or damage by burglary, theft, robbery, forgery, fraud, deceptive practices, vandalism, criminal mischief, confiscation, or wrongful conversion, disposal, or concealment or from any attempt at any of the foregoing, including supplemental coverage for medical, hospital, surgical, and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery, or theft by another; and

(ii) insurance against loss of or damage to money, coins, bullion, securities, notes, drafts, acceptances, or any other valuable papers and documents, resulting from any cause;

(e) personal property floater, which is insurance upon personal effects against loss or damage from any cause under a personal property floater;

(f) glass, which is insurance against loss or damage to glass, including its lettering, ornamentation, and fittings;

(g) boiler and machinery, which is insurance against any liability and loss or damage to property or interest resulting from accident to or explosions of boilers, pipes, pressure containers, machinery, or apparatus and from making inspection of and issuing certificates of inspection upon boilers, machinery, and apparatus of any kind, whether or not insured;

(h) leakage and fire extinguishing equipment, which is insurance against loss or damage to any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus, water pipes, or containers or by water entering through leaks or openings in buildings and insurance against loss or damage to the sprinklers, hoses, pumps, and other fire extinguishing equipment or apparatus;

(i) credit, which is insurance against loss or damage resulting from failure of debtors to pay their obligations to the insured;

(j) malpractice, which is insurance against legal liability of the insured and against loss, damage, or expense incidental to a claim of liability, including medical, hospital, surgical, and funeral benefits to injured persons, irrespective of legal liability of the insured, arising out of the death, injury, or disablement of any person or arising out of damage to the economic interest of any person, as the result of negligence in rendering expert, fiduciary, or professional service;

(k) elevator, which is insurance against loss of or damage to any property of the insured, resulting from the ownership, maintenance, or use of elevators, except loss or damage by fire and from making inspection of and issuing certificates of inspection upon elevators;

(l) livestock, which is insurance against loss or damage to livestock and for services of a veterinarian for livestock;

(m) entertainments, which is insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment, or similar production, event, or exhibition against loss from interruption, postponement, or cancellation because of death, accidental injury, or sickness of performers, participants, directors, or other principals;

(n) mechanical breakdown pursuant to 33-1-214;

(o) prepaid legal pursuant to 33-1-215;

(p) involuntary unemployment pursuant to 33-1-216;

(q) gap pursuant to 33-1-217;

(r) miscellaneous, which is insurance against any other kind of loss, damage, or liability properly a subject of insurance and not within any other kind of insurance as defined in this part, if the insurance is not disapproved by the commissioner as being contrary to law or public policy.

(2) Provision of medical, hospital, surgical, and funeral benefits and of coverage against accidental death or injury as incidental to and part of other insurance as stated under subsections (1)(a) (vehicle), (1)(b) (liability), (1)(d) (burglary), and (1)(j) (malpractice) must for all purposes be considered to be the same kind of insurance to which it is incidental and is not subject to provisions of this code applicable to life or disability insurances.

History: En. Sec. 76, Ch. 286, L. 1959; amd. Sec. 49, Ch. 359, L. 1977; R.C.M. 1947, 40-2905; amd. Sec. 9, Ch. 227, L. 2001.

Cross-References

Medical malpractice — panel to review claims, Title 27, ch. 6.
Casualty insurance — general provisions, Title 33, ch. 23, part 1.
Workers' compensation — plans for providing, Title 39, ch. 71, parts 21 through 23.
Robbery, 45-5-401.
Crimes against property, Title 45, ch. 6.
Elevators — inspection and maintenance, Title 50, ch. 60, part 7.
Boilers and boiler inspectors, Title 50, ch. 74, part 2.

33-1-207. Disability insurance. (1) Disability insurance, including credit disability insurance, is insurance of human beings:

(a) against bodily injury, disablement, or death by accident or accidental means or the medical expense or indemnity involved; or

(b) against disablement or medical expense or indemnity resulting from sickness.

(2) Transaction of disability insurance does not include:

(a) workers' compensation insurance; or

(b) a direct patient care agreement established pursuant to 50-4-107.

History: En. Sec. 74, Ch. 286, L. 1959; R.C.M. 1947, 40-2903; amd. Sec. 2, Ch. 379, L. 1995; amd. Sec. 8, Ch. 262, L. 2021.

Cross-References

Disability insurance — general provisions, Title 33, ch. 22, part 1.
Workers' compensation insurance — general coverage and operation, Title 39, ch. 71, part 4.

33-1-208. Life insurance. Life insurance, including credit life insurance, is insurance on human lives. The transaction of life insurance includes the granting of endowment benefits, additional benefits in event of death or dismemberment by accident or accidental means, additional benefits in event of the insured's disability, benefits that provide reimbursement or payment for long-term home health care or long-term care in a nursing home or other related institution, and optional modes of settlement of proceeds of life insurance. Transaction of life insurance does not include workers' compensation insurance.

History: En. Sec. 73, Ch. 286, L. 1959; R.C.M. 1947, 40-2902; amd. Sec. 1, Ch. 152, L. 1991; amd. Sec. 3, Ch. 379, L. 1995.

Cross-References

Life insurance — general provisions, Title 33, ch. 20.

Workers' compensation insurance — general coverage and operation, Title 39, ch. 71, part 4.

33-1-209. Marine protection and indemnity and wet marine insurance. (1) Marine and transportation insurance means insurance against loss of or damage to:

(a) vessels, craft, aircraft, vehicles, goods, freights, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia, and any interest therein, with respect to risks and perils, including war risks, marine builder's risks, and personal property floater risks, of navigation and transportation or while being assembled, packed, crated, baled, compressed, or similarly prepared for shipment, while awaiting shipment, or during any delays, storage, transshipment, or reshipment;

(b) person or property in connection with marine, transit, or transportation insurance, including liability for loss or damage to either person or property incident to the construction, repair, operation, maintenance, or use of the subject matter of the insurance, but not including life insurance, surety bonds, or insurance against bodily injury arising out of the ownership, maintenance, or use of an automobile;

(c) jewels, jewelry, or precious metals, whether in the course of transportation or otherwise; and

(d) bridges; tunnels; and other instrumentalities of transportation and communication, excluding buildings and their furnishings, fixed contents, and supplies held in storage (unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot, or civil commotion are the only hazards to be covered); piers; wharves; docks; slips; and other aids to navigation and transportation, including drydocks, marina railways, and dams and appurtenant facilities for the control of waterways.

(2) Marine protection and indemnity insurance means insurance against liability of the insured for loss, damage, or expense incident to ownership, operation, charter, maintenance, use, repair, or construction of any vessel, craft, or instrumentality for use in ocean or inland waterways. The term includes insurance against the liability of the insured for personal injury, illness, death, or loss or damage of the property of another person.

(3) For the purposes of this code, wet marine and transportation insurance is that part of marine insurance that includes only:

(a) insurance upon vessels, crafts, and hulls and of interests in or relating to the vessels, crafts, and hulls;

(b) insurance of marine builders' risks, marine war risks, and contracts of marine protection and indemnity insurance;

(c) insurance of freights and disbursements pertaining to a subject of insurance subject to this subsection; and

(d) insurance of personal property and interests in the personal property, in the course of exportation from or importation into any country and in the course of transportation coastwise or on inland waters, including transportation by land, water, or air from point of origin to final destination, with respect to risks or perils of navigation, transit, or transportation or while being prepared for or awaiting shipment or during any delays, storage, transshipment, or reshipment incident to preparation or shipment.

History: En. Sec. 78, Ch. 286, L. 1959; R.C.M. 1947, 40-2907; amd. Sec. 11, Ch. 467, L. 1981; amd. Sec. 4, Ch. 379, L. 1995.

Cross-References

Nationwide inland marine law, 33-1-221 through 33-1-229.

33-1-210. Property insurance. Property insurance is insurance on real or personal property of every kind and of every interest therein, whether on land, water, or in the air, against loss or damage from any and all hazard or cause, and against loss consequential upon such loss or damage, other than noncontractual legal liability for any such loss or damage.

History: En. Sec. 75, Ch. 286, L. 1959; R.C.M. 1947, 40-2904.

Cross-References

Property insurance — general provisions, Title 33, ch. 24.

33-1-211. Surety insurance. Surety insurance includes:

(1) fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust;

(2) insurance guaranteeing the performance of contracts, other than insurance policies, and guaranteeing and executing bonds, undertakings, and contracts of suretyship;

(3) insurance indemnifying banks, bankers, brokers, or financial or moneyed corporations or associations:

(a) against check forgery or alteration or against loss resulting from any cause of bills of exchange, notes, bonds, securities, evidences of debt, deeds, mortgages, warehouse receipts, or other valuable papers, documents, money, precious metals and articles made from precious metals, jewelry, watches, necklaces, bracelets, gems, or precious and semiprecious stones, including any loss while being transported in armored motor vehicles, by mail, or by messenger but not including any other risks of transportation or navigation;

(b) against loss or damage to the insured's premises or to the insured's furnishings, fixtures, equipment, safes, and vaults on the premises caused by burglary, robbery, theft, or criminal mischief or any attempt of those crimes.

History: En. Sec. 77, Ch. 286, L. 1959; amd. Sec. 50, Ch. 359, L. 1977; R.C.M. 1947, 40-2906; amd. Sec. 3, Ch. 198, L. 1979; amd. Sec. 1059, Ch. 56, L. 2009.

Cross-References

Guaranty, indemnity, and suretyship, Title 28, ch. 11.

33-1-212. Title insurance. Title insurance is insurance of owners of property or others having an interest therein or liens or encumbrances thereon against loss by encumbrance, defective titles, invalidity, or adverse claim to title.

History: En. Sec. 79, Ch. 286, L. 1959; R.C.M. 1947, 40-2908.

Cross-References

Title insurance — general provisions, Title 33, ch. 25.

33-1-213. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 64, Ch. 472, L. 1999.

33-1-214. Mechanical breakdown insurance. (1) Mechanical breakdown insurance means a policy, contract, or agreement issued by an authorized insurer that provides for the repair, replacement, or service for the operational or structural failure of the property because of a defect in materials or workmanship or because of normal wear and tear.

(2) The term does not include motor club services, as defined in 61-12-301.

(3) Mechanical breakdown insurance is a type of casualty insurance provided for in 33-1-206.

History: En. Sec. 65, Ch. 472, L. 1999; amd. Sec. 10, Ch. 227, L. 2001.

33-1-215. Prepaid legal insurance. (1) For the purposes of this section, prepaid legal insurance means the assumption of a contractual obligation that is to be spread, directly or indirectly, among a group of persons to provide specified legal services or reimbursement for legal expenses in consideration of a specified payment for an interval of time, regardless of whether the payment is made by the beneficiary or by a third person on behalf of the beneficiary.

(2) Prepaid legal insurance does not include the provision of or reimbursement for legal services that are incidental to other insurance coverage. The following are not prepaid legal insurance:

(a) retainer contracts made with individual clients with fees based on estimates of the nature and amount of services that will be required;

(b) contracts made with a group of clients involved in the same or closely related legal matters;

(c) plans providing only a referral service or a discount card for legal services;

(d) legal services provided by unions or employee associations to members pertaining to employment or occupation; or

(e) legal services provided by an agency of state or federal government to employees.

(3) Prepaid legal insurance is a type of casualty insurance provided for in 33-1-206.

History: En. Sec. 66, Ch. 472, L. 1999; amd. Sec. 11, Ch. 227, L. 2001.

33-1-216. Involuntary unemployment insurance. (1) Involuntary unemployment insurance means insurance providing the insured borrower with coverage for consumer credit replacement obligations for a period or periods during which the borrower is involuntarily unemployed. Involuntary unemployment insurance must at least provide benefits for the loss of employment income caused by individual or mass layoff, a general strike, termination by an employer, a dispute involving organized labor, and a lockout.

(2) Involuntary unemployment insurance is a type of casualty insurance provided for in 33-1-206.

History: En. Sec. 67, Ch. 472, L. 1999; amd. Sec. 12, Ch. 227, L. 2001.

33-1-217. Gap amount — gap insurance. (1) As used in this section, gap amount means the difference between the amount owed by the lessee or borrower under the purchase or lease agreement in the event of total loss of the personal property prior to the expiration of the agreement by theft or physical damage and the actual cash value or portion received by the lessor or creditor from insurance proceeds or from any other person on account of the total loss or destruction of the personal property.

(2) Gap insurance means insurance covering the gap amount that is payable upon the total loss of personal property, which is the subject of a lease or a loan or another credit transaction, occasioned by the theft of or physical damage to the property.

(3) Gap insurance is a type of casualty insurance provided for in 33-1-206.

History: En. Sec. 68, Ch. 472, L. 1999; amd. Sec. 13, Ch. 227, L. 2001.

33-1-218. Credit insurances — definitions. As used in this code, the following definitions apply:

(1) "Credit disability insurance" means the same as defined in 33-21-103.

(2) "Credit life insurance" means the same as defined in 33-21-103.

(3) "Credit property insurance" means any policy, endorsement, rider, cover note, memorandum, certificate, or other instrument or evidence of insurance covering perils to goods purchased through a credit transaction or pledged as collateral for a credit transaction and that concerns a creditor's interest in the purchased goods or pledged collateral either in whole or in part. Credit property insurance is a type of property insurance as provided for in 33-1-210.

(4) "Credit unemployment insurance" means insurance on a debtor to provide indemnity for payments or debt becoming due on a specific loan or other credit transaction while the debtor is involuntarily unemployed as defined in the policy. Credit unemployment insurance is a type of involuntary unemployment insurance as provided for in 33-1-216.

(5) "Debtor" means the same as defined in 33-21-103.

History: En. Sec. 9, Ch. 106, L. 2001.

33-1-219. Mortgage insurances — definitions. (1) "Mortgage" or "mortgage loan" is an indebtedness of more than 10 years duration that is secured by a real estate mortgage.

(2) "Mortgage disability insurance" is disability insurance designed to pay off all or a part of a mortgage loan in the event of the insured's disability. Mortgage disability insurance is a type of credit disability insurance.

(3) (a) "Mortgage guaranty insurance" is:

(i) insurance against financial loss by reason of nonpayment of principal, interest, or other sums agreed to be paid under the terms of any note, bond, or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate if the improvement of the real estate is a residential building, a condominium unit, or other building designed for occupancy by not more than four families;

(ii) insurance against financial loss by reason of nonpayment of principal, interest, or other sums agreed to be paid under the terms of any note, bond, or other evidence of indebtedness secured by a mortgage, deed of trust, or other instrument constituting a lien or charge on real estate if the improvement on the real estate is a building or buildings designed for occupancy by five or more families or is designed to be occupied for industrial or commercial purposes; or

(iii) insurance against financial loss by reason of nonpayment of rent or other sums agreed to be paid under the terms of a written lease for the possession, use, or occupancy of real estate if the improvement of the real estate is a building or buildings designed to be occupied for industrial or commercial purposes.

(b) Mortgage guaranty insurance is a type of casualty insurance as provided for in 33-1-206.

(4) "Mortgage life insurance" is life insurance designed to pay off all or a part of a mortgage loan in the event of the insured's death. Mortgage life insurance is a type of credit life insurance as defined in 33-21-103.

History: **En. Sec. 10, Ch. 106, L. 2001.**

33-1-220. Rental car insurance. Rental car insurance is insurance that:

(1) provides coverage for periods of less than 90 days;

(2) applies only to the rental car subject to the rental agreement; and

(3) is limited to the following kinds of insurance:

(a) personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(b) liability insurance that provides protection to the renters and other authorized drivers of a rental car for liability arising from the operation or use of the rental car during the rental period;

(c) personal effects insurance that provides coverage to renters and other vehicle occupants for loss of or damage to personal effects in the rental car during the rental period; or

(d) motor club services, as defined in 61-12-301.

History: **En. Sec. 3, Ch. 427, L. 2003.**

33-1-221. Nationwide inland marine definition law. Sections 33-1-221 through 33-1-229 may be cited as the "Nationwide Inland Marine Definition Act".

History: **En. Sec. 1, Ch. 467, L. 1981.**

33-1-222. Purpose. (1) The purpose of 33-1-221 through 33-1-229 is to describe the kinds of risks and coverages which may be classified or identified under state insurance laws as marine, inland marine, or transportation insurance, but 33-1-221 through 33-1-229 do not include all of the kinds of risks and coverages which may be written, classified, or identified under marine, inland marine, or transportation insuring powers. Sections 33-1-221 through 33-1-229 may not be construed to mean that the kinds of risks and coverages described herein are solely marine, inland marine, or transportation insurance in all instances.

(2) Sections 33-1-221 through 33-1-229 may not be construed to restrict or limit in any way the exercise of any insuring powers granted under charters and licenses whether used separately, in combination, or otherwise.

History: **En. Sec. 2, Ch. 467, L. 1981.**

33-1-223. Imports. Imports may be covered by marine, inland marine, and transportation policies subject to the following conditions:

(1) Imports are covered wherever they are located, without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

(2) Property is an import and the proper subject of marine, inland marine, or transportation insurance as long as the property remains segregated in such a way that it can be identified and has not become incorporated into and mixed with the general mass of property in the United States; property ceases to be an import and the proper subject of marine, inland marine, or transportation insurance when it has been:

(a) sold and delivered by the importer, factor, or consignee;

(b) removed from its place of storage and placed on sale as part of an importer's stock in trade at a point of sale or distribution; or

(c) delivered for manufacture, processing, or change in form to premises of the importer or another, to be used for such purposes.

History: **En. Sec. 3, Ch. 467, L. 1981.**

33-1-224. Exports. Exports may be covered by marine, inland marine, and transportation policies subject to the following conditions:

(1) Exports are covered wherever they are located, without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

(2) Property is an export and the proper subject of marine, inland marine, or transportation insurance when designated or while being prepared for export and remains an export unless diverted for domestic trade. If the property is diverted for domestic trade, the provisions of 33-1-225 apply. This section does not apply to long-established methods of insuring certain commodities such as cotton.

History: En. Sec. 4, Ch. 467, L. 1981.

33-1-225. Domestic shipments. Domestic shipments may be covered by marine, inland marine, and transportation policies subject to the following conditions:

(1) Domestic shipments on consignment for sale, distribution, exhibit, trial, approval, or auction may be covered while in transit, while in the custody of others, and while being returned, except that the policy may not cover property while it is on premises owned, leased, or operated by the consignor.

(2) Domestic shipments not on consignment may be covered if the coverage of the issuing companies includes hazards of transportation beginning and ending within the United States. Such shipments are not covered at the manufacturing premises or after arrival at premises owned, leased, or operated by the assured or the purchaser.

History: En. Sec. 5, Ch. 467, L. 1981.

33-1-226. Instrumentalities of transportation and commerce. Bridges, tunnels, and other instrumentalities of transportation and communication (excluding buildings and improvements, furniture, furnishings, fixed contents, and supplies held in storage) may be covered by marine, inland marine, and transportation policies. This category includes:

(1) bridges, tunnels, and other similar instrumentalities, including auxiliary facilities and equipment attendant thereto;

(2) piers, wharves, docks, slips, drydocks, and marine railways;

(3) pipelines, including on-line propulsion, regulating, and other equipment appurtenant to such pipelines but excluding all property at manufacturing, producing, refining, converting, treating, or conditioning plants;

(4) power transmission, telephone, and telegraph lines, excluding all property at generating, converting, or transforming stations, substations, and exchanges;

(5) radio and television communication equipment in use as such, including towers and antennas with auxiliary equipment, and appurtenant electrical operating and control apparatus; and

(6) outdoor cranes, loading bridges, and similar equipment used to load, unload, and transport.

History: En. Sec. 6, Ch. 467, L. 1981.

33-1-227. Personal property. Risks generally covered by personal property floaters covering individuals or items of personal property may be covered by marine, inland marine, and transportation policies. This category includes:

(1) personal effects floater policies;

(2) personal property floaters;

(3) government service floaters;

(4) personal fur floaters;

(5) personal jewelry floaters;

(6) wedding present floaters for a period not exceeding 90 days after the date of the wedding;

(7) silverware floaters;

(8) fine arts floaters covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value, or artistic merit;

(9) stamp and coin floaters;

(10) musical instrument floaters. For purposes of this section, radios, televisions, record players, and combinations thereof are not musical instruments.

(11) mobile articles, machinery, and equipment floaters (excluding motor vehicles designed for highway use and motor homes, trailers, and semitrailers except when hauled by tractors not designed for highway use) covering identified property of a mobile or floating nature pertaining to or usual to a household. Such policies shall not cover furniture and fixtures not customarily used away from premises where such property is usually kept.

(12) installment sales and leased property policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract, or installment sales contract or leased but excluding motor vehicles designed for highway use. Such policies must cover property in transit but shall not extend beyond the termination of the seller's or lessor's interest; and

(13) live animal floaters.

History: En. Sec. 7, Ch. 467, L. 1981.

33-1-228. Commercial property. Risks generally covered by commercial property floaters covering property pertaining to a business, profession, or occupation may be covered by marine, inland marine, and transportation policies. This category includes:

(1) radium floaters;

(2) physicians' and surgeons' instrument floaters. The policies may include coverage of furniture, fixtures, and tenant assured's interest in the improvements of buildings that are located in that portion of the premises occupied by the assured in the practice of the assured's profession.

(3) pattern and die floaters;

(4) theatrical floaters, excluding buildings and improvements, furniture, and fixtures that do not travel with theatrical troupes;

(5) film floaters, including a builders' risk during the production and coverage on completed negatives, positives, and sound records;

(6) salesperson's samples floaters;

(7) exhibition policies on property while it is on exhibition and in transit to or from exhibitions;

(8) live animal floaters;

(9) builders' risks and installation risks policies covering the interest of owner, seller, or contractor against loss or damage to machinery, equipment, building materials, or supplies being used with and during the course of installation, testing, building, renovating, or repairing. These policies may cover property at points or places where work is being performed, while in transit, and during temporary storage or deposit of property designated for an awaiting specific installation, building, renovating, or repairing. The coverage is limited to builders' risks or installation risks when perils in addition to fire and extended coverage are to be insured. If written for the account of the owner, the coverage ceases upon completion of work and acceptance of the work, or if written for the account of a seller or contractor, the coverage terminates when the interest of the seller or contractor terminates.

(10) mobile articles, machinery, and equipment floaters, excluding motor vehicles designed for highway use and motor homes, trailers, and semitrailers except when hauled by tractors not designed for highway use, and snowplows constructed exclusively for highway use, covering identified property of a mobile or floating nature, not on sale or consignment or in the course of manufacture, that has come into custody or control of parties who intend to use the property for which it was manufactured or created. The policies may not cover furniture and fixtures not customarily used away from premises where the property is usually kept.

(11) property in transit to or from and in the custody of bailees, not owned, controlled, or operated by the bailor, but the policies may not cover the bailee's property at the bailee's premises;

(12) installment sales and leased property policies covering property sold under conditional contract of sale, partial payment contract or installment sales contract or leased, but excluding motor vehicles designed for highway use. These policies must cover property in transit but may not extend beyond the termination of the seller's or lessor's interest. This subsection does not include machinery and equipment under certain "lease-back" contracts.

(13) garment contracts' floaters;

(14) furriers' or fur storers' customer's policies, which are policies under which certificates or receipts are issued by furriers or fur storers, covering specified articles that are the property of customers;

(15) accounts receivable policies and valuable papers and records policies;

(16) floor plan policies, covering property for sale while in possession of dealers under a floor plan or any similar plan under which the dealer borrows money from a bank or lending institution to pay the manufacturer if:

(a) the merchandise is specifically identifiable as encumbered to the bank or lending institution;

(b) the dealer's right to sell or otherwise dispose of the merchandise is conditioned upon its being released from encumbrance by the bank or lending institution; and

(c) the policies cover property in transit and do not extend beyond the termination of the dealer's interest;

(17) sign and street clock policies, including neon signs, automatic or mechanical signs, and street clocks, while in use as intended;

(18) fine arts policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value, or artistic merit, for account of museums, galleries, universities, businesses, municipalities, and other similar interests;

(19) policies covering personal property, which may include coverage of money in locked safes or vaults on the assured's premises and may also include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies, and a tenant insured's interest in improvements of buildings, which when sold to the ultimate purchaser may be covered specifically by the owner under inland marine policies, including:

(a) musical instrument dealers' policies, covering property consisting principally of musical instruments and their accessories, but radios, televisions, record players, and combinations of them are not musical instruments for the purposes of this subsection;

(b) camera dealers' policies covering property consisting principally of cameras and their accessories;

(c) furrier dealers' policies covering property consisting principally of furs and fur garments;

(d) equipment dealers' policies covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders, and other similar agricultural equipment and accessories for the equipment and covering construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools, and similar equipment and accessories for the equipment, but excluding motor vehicles designed for highway use;

(e) stamp and coin dealers' policies covering property of philatelic and numismatic nature;

(f) jewelers' block policies; and

(g) fine arts dealers' policies;

(20) wool growers' floaters;

(21) domestic bulk liquids policies covering tanks and domestic bulk liquids stored in the tanks;

(22) "difference in conditions" coverage, excluding fire and extended coverage perils; and

(23) electronic data processing policies.

History: En. Sec. 8, Ch. 467, L. 1981; amd. Sec. 1060, Ch. 56, L. 2009.

33-1-229. Exceptions. Unless otherwise permitted, nothing in 33-1-223 through 33-1-229 may be construed to permit marine, inland marine, or transportation insurance policies to cover:

(1) storage of an assured's merchandise, except as specifically provided;

(2) merchandise in the course of manufacture which is the property of and on the premises of the manufacturer;

(3) furniture, fixtures, and improvements to buildings; or

(4) money or securities in safes, vaults, safety deposit vaults, or banks or on the assured's premises, except while in the course of transportation.

History: En. Sec. 9, Ch. 467, L. 1981.

33-1-230 through 33-1-234 reserved.

33-1-235. Disability income insurance. "Disability income insurance" means an individual or group policy of insurance that primarily provides payment to or for the benefit of the policyholder or certificate holder based, in whole or in part, upon lost wages or other earned income or business or financial losses as a result of an inability to work due to sickness, injury, or a combination of sickness and injury.

History: **En. Sec. 5, Ch. 380, L. 2003.**

Part 3
Commissioner and Department General Powers and Duties

33-1-301. Insurance department — control — appropriations. (1) The insurance department shall be under the control and supervision of the commissioner.

(2) Funds adequate for the maintenance and operation of the insurance department shall be expressly appropriated by the legislature and shall be used solely for the purposes for which so appropriated.

History: **En. Sec. 21, Ch. 286, L. 1959; R.C.M. 1947, 40-2702(2), (3).**

Cross-References

Insurance Department — creation, 2-15-1902.

State Auditor — ex officio Insurance Commissioner, 2-15-1903.

33-1-302. Commissioner's seal. (1) The commissioner must have a seal of office consisting of the same symbolic design within the inner circle as the great seal of the state of Montana, encircled by the words "Commissioner of Insurance, State of Montana".

(2) All certificates and licenses issued by the commissioner must bear the seal, except that the commissioner may omit the seal for licenses.

History: **En. Sec. 22, Ch. 286, L. 1959; R.C.M. 1947, 40-2703; amd. Sec. 1061, Ch. 56, L. 2009.**

Cross-References

The Great Seal of the State of Montana — description, 1-1-501.

33-1-303. Deputies and assistants — employment, compensation, and termination. (1) The commissioner shall appoint a chief deputy insurance commissioner who is in charge of the insurance department under the direction and control of the commissioner.

(2) The commissioner may appoint additional deputy insurance commissioners for the purposes that the commissioner designates.

(3) The commissioner may employ a competent insurance actuary to perform actuarial duties, if any, of the department, to take charge of or assist in the examination of insurers, and to perform other duties assigned to the commissioner.

(4) The commissioner may appoint or employ examiners to conduct or assist in examinations of insurers and others provided for under the code. Examiners must be competent, because of experience or special education or training, to fulfill the responsibilities of an insurance examiner.

(5) The commissioner shall appoint or employ insurance protection analysts for the purpose of ensuring that insurers and their representatives comply with market regulations provided by law.

(6) The commissioner may appoint and employ a field investigator whose primary duty it is, as directed by the commissioner, to make investigations in this state of violations or claimed violations of this code.

(7) The commissioner may appoint a chief clerk for the insurance department and employ other assistants and clerks as may be necessary to assist the commissioner properly to discharge the duties imposed under this code.

(8) The commissioner may at any time terminate the appointment, designation, or employment of any deputy, actuary, chief clerk, or other employee.

(9) The commissioner may from time to time contract for and procure, on a fee or part-time basis, or both, actuarial, technical, or other professional services as the commissioner may require for the discharge of duties.

(10) The compensation of the commissioner's personal staff, as defined in Title 2, chapter 18, part 1, shall be as fixed by the commissioner but in the aggregate may not exceed current

funds appropriated by the legislature to the insurance department or otherwise currently available for the purpose.

History: **En. Sec. 23, Ch. 286, L. 1959; R.C.M. 1947, 40-2704; amd. Sec. 1, Ch. 4, L. 1979; amd. Sec. 4, Ch. 198, L. 1979; amd. Sec. 1, Ch. 165, L. 1993.**

Cross-References

Deputies of public officers, Title 2, ch. 16, part 3.
State employee classification, compensation, and benefits, Title 2, ch. 18.
Personal staff, 2-18-104.

33-1-304. Delegation of authority — responsibility. (1) The commissioner may delegate to any deputy, assistant, examiner, or employee of the commissioner's department the exercise or discharge in the commissioner's name of any power, duty, or function, whether ministerial or discretionary, vested by this code in the commissioner.

(2) The commissioner is responsible for the official acts of the commissioner's deputy, assistant, examiner, or employee acting in the commissioner's name and by the commissioner's authority.

History: **En. Sec. 25, Ch. 286, L. 1959; R.C.M. 1947, 40-2706; amd. Sec. 1062, Ch. 56, L. 2009.**

Cross-References

Powers of deputies, 2-16-303.

33-1-305. Conflicts of interest prohibited. The commissioner or any deputy, examiner, assistant, or employee of the commissioner:

(1) may not be financially interested, directly or indirectly, in any insurer, insurance agency, or insurance transaction except as a policyholder or claimant under a policy; and

(2) is subject to the ethics provisions in Title 2, chapter 2.

History: **En. Sec. 24, Ch. 286, L. 1959; R.C.M. 1947, 40-2705(part); amd. Sec. 1, Ch. 62, L. 2019.**

Cross-References

Code of ethics, Title 2, ch. 2, part 1.
Interest in certain contracts — prohibition, 2-2-201.
Official misconduct — crime, 45-7-401.

33-1-306. Dual contracts permitted. As to such matters wherein a conflict of interest does not exist on the part of any such individual, the commissioner may employ or retain from time to time insurance actuaries, attorneys, or other technicians who are independently practicing their professions even though similarly employed or retained by insurers or others.

History: **En. Sec. 24, Ch. 286, L. 1959; R.C.M. 1947, 40-2705(part).**

Cross-References

Code of ethics, Title 2, ch. 2, part 1.

33-1-307 through 33-1-310 reserved.

33-1-311. General powers and duties. (1) The commissioner shall enforce the applicable provisions of the laws of this state and shall execute the duties imposed on the commissioner by the laws of this state.

(2) The commissioner has the powers and authority expressly conferred upon the commissioner by or reasonably implied from the provisions of the laws of this state.

(3) Except as otherwise provided in 33-39-101, the commissioner shall administer the department to ensure that the interests of insurance consumers are protected.

(4) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the commissioner considers proper, to determine whether any person has violated any provision of the laws of this state or to secure information useful in the lawful administration of any provision. The cost of additional examinations and investigations must be borne by the state.

(5) The commissioner shall maintain as confidential any information or document received from:

(a) the national association of insurance commissioners; or

(b) another state agency, an insurance department from another state, a federal agency, the interstate insurance product regulation commission, or a foreign government that treats the same information or document as confidential. The commissioner may provide information or documents, including information or documents that are confidential, to another state agency, the national association of insurance commissioners, a state or federal law enforcement agency, a federal agency, the interstate insurance product regulation commission, a foreign government, or an insurance department in another state if the recipient agrees to maintain the confidentiality of the information or documents.

(6) The department is a criminal justice agency as defined in 44-5-103.

History: En. Sec. 28, Ch. 286, L. 1959; amd. Sec. 1, Ch. 16, L. 1969; R.C.M. 1947, 40-2709(1) thru (3), (5); amd. Sec. 1, Ch. 99, L. 1989; amd. Sec. 2, Ch. 165, L. 1993; amd. Sec. 5, Ch. 379, L. 1995; amd. Sec. 10, Ch. 472, L. 1999; amd. Sec. 14, Ch. 227, L. 2001; amd. Sec. 2, Ch. 399, L. 2007; amd. Sec. 6, Ch. 227, L. 2011; amd. Sec. 4, Ch. 360, L. 2013.

Cross-References

Deductible insurance plan for state buildings — cooperation, 2-17-104.
Fire departments — report, 19-18-511.
Development credit corporations — report, 32-4-306.
License required of health service corporations, 33-30-108.

33-1-312. Records and certificates. (1) The commissioner shall enter in permanent form records of the commissioner's official transactions, examinations, investigations, and proceedings and keep the records in the commissioner's office. The records and insurance filings in the commissioner's office must be open to public inspection except as otherwise provided in this code with respect to particular records or filings.

(2) When required, the commissioner shall furnish a certificate as to the authority of any person to transact insurance, and the certificate must be evidence of the facts set forth in the certificate.

(3) Copies of records or documents in the commissioner's office certified to by the commissioner must be received in evidence in all courts as if they were the originals.

History: (1)En. Sec. 26, Ch. 286, L. 1959; Sec. 40-2707, R.C.M. 1947; (2), (3)En. Sec. 27, Ch. 286, L. 1959; Sec. 40-2708, R.C.M. 1947; R.C.M. 1947, 40-2707, 40-2708; amd. Sec. 1063, Ch. 56, L. 2009.

Cross-References

Records of officers — public examination allowed, 2-6-1003.

33-1-313. Rules. The commissioner may make reasonable rules necessary for or as an aid to the effective administration of any provision of this code.

History: En. Sec. 29, Ch. 286, L. 1959; R.C.M. 1947, 40-2710; amd. Sec. 80, Ch. 370, L. 1987; amd. Sec. 6, Ch. 606, L. 1987; amd. Sec. 15, Ch. 227, L. 2001.

Cross-References

Applicability of MAPA to agencies, 2-3-102, 2-4-102.
Montana Administrative Procedure Act (MAPA), Title 2, ch. 4.
Rules for organization or procedure of agency, 2-4-201.
Notice and hearing for rule adoption, 2-4-302.
Requisites for validity of rule, 2-4-305.
Publication of rule required, 2-4-306.
Administrative penalties, 33-1-317.
Discrimination in insurance and retirement plans, 49-2-309.

33-1-314. Orders and notices. (1) Orders and notices of the commissioner are not effective unless in writing, signed by the commissioner or by the commissioner's authority.

(2) Each order must state its effective date and must concisely state:

(a) its intent or purpose;

(b) the grounds on which the order is based;

(c) the provisions of this code pursuant to the action taken or proposed to be taken, but failure to designate a particular provision does not deprive the commissioner of the right to rely on a particular provision.

(3) The commissioner may effect service of process of an order or notice by mailing it, postage prepaid, addressed to the person affected by the order or notice, to the person's principal place of business as recorded in the commissioner's office. The commissioner's order is effective when mailed. If the commissioner does not have a record of the person's principal place of business, the commissioner may effect service of process of an order or notice upon a person by mailing it, postage prepaid, to the address as listed on the person's driver's license, as ascertained by the commissioner through the motor vehicle division of the department of justice, or, if a partnership, corporation, or similar entity, as ascertained from documentation filed in the office of the secretary of state.

(4) The commissioner may have a person served pursuant to Rule 4(c)(2)(C), (c)(2)(D), and (d) through (s) of the Montana Rules of Civil Procedure.

History: En. Sec. 30, Ch. 286, L. 1959; R.C.M. 1947, 40-2711; amd. Sec. 16, Ch. 227, L. 2001.

33-1-315. Witnesses — production of records — subpoena — failure to respond. (1) With respect to the subject of any examination or investigation being conducted by the commissioner, or the commissioner's designee if general written authority has been given the designee by the commissioner, the commissioner or the designee may subpoena witnesses and administer oaths or affirmations and examine any individual under oath and may require and compel the production of records, books, papers, contracts, and other documents by attachments, if necessary. Subpoenas of witnesses must be served in the same manner as if issued from a district court.

(2) If in connection with an examination of an insurer the commissioner or the commissioner's designee desires to examine an officer, director, or manager who is outside this state, the commissioner or the commissioner's designee may conduct and enforce by all appropriate and available means any examination under oath in any other state or territory of the United States in which the officer, director, or manager is located, to the full extent permitted by the laws of that state or territory.

(3) If a witness fails to obey a subpoena to appear before the commissioner or the commissioner's designee or refuses to testify or answer any material question or to produce records, books, papers, contracts, or documents when required to do so, the commissioner or the commissioner's designee shall institute proceedings in the district court to compel obedience to the subpoena or other order or to punish the witness for neglect or refusal to obey the summons or other order.

(4) Witness fees and mileage, if claimed, must be allowed on the same basis as for testimony in a district court. Witness fees, mileage, and the actual expenses necessarily incurred in securing attendance of witnesses and their testimony must be itemized and paid by the person being examined if the person is found to have been in violation of the law as to the matter with respect to which the witnesses were subpoenaed.

(5) A person who knowingly fails to attend, answer, and produce records, documents, or other evidence requested by the commissioner or the commissioner's designee, who knowingly fails to give full and truthful information or to answer in writing to any material inquiry of the commissioner or the commissioner's designee relative to the subject of an examination, investigation, or hearing, or who knowingly fails to appear and testify under oath before the commissioner or the commissioner's designee is subject to the provisions of 33-1-317 and 33-1-318.

History: En. Sec. 37, Ch. 286, L. 1959; R.C.M. 1947, 40-2718; amd. Sec. 5, Ch. 198, L. 1979; amd. Sec. 17, Ch. 227, L. 2001; amd. Sec. 3, Ch. 493, L. 2003.

Cross-References

Travel allowance — mileage, 2-18-503, 2-18-504.
Disobedience of subpoena, 26-2-104.
Witness fees, Title 26, ch. 2, part 5.
Perjury — crime, 45-7-201.
Misdemeanor, 46-18-212.

33-1-316. Testimony compelled — immunity from prosecution. (1) A person may not be excused from attending and testifying or producing any evidence in any examination or investigation conducted by or under authority of the commissioner on the ground that the person's testimony or the evidence required may tend to incriminate or subject the person to a penalty or forfeiture. However, testimony or evidence compelled following a claim of privilege against self-incrimination or any information directly or indirectly derived from compelled testimony or evidence may not be used against the person in a criminal prosecution.

(2) The commissioner may grant immunity from prosecution for or on account of any act, occurrence, transaction, matter, or other thing concerning which a person testifies if the commissioner determines that the ends of justice would be served by granting the additional immunity.

(3) Immunity does not extend to prosecution or punishment for false statements by the person that are contained in testimony or evidence given under this part.

History: En. Sec. 38. Ch. 286, L. 1959; R.C.M. 1947, 40-2719; amd. Sec. 1, Ch. 246, L. 1991; amd. Sec. 1, Ch. 451, L. 1993; amd. Sec. 18, Ch. 227, L. 2001.

Cross-References

Self-incrimination, Art. II, sec. 25, Mont. Const.

33-1-317. Penalty imposed by commissioner. The commissioner may, after having conducted a hearing pursuant to 33-1-701, impose a fine not to exceed the sum of $25,000 upon a person found to have violated a provision of this code or regulation promulgated by the commissioner, except that the fine imposed upon insurance producers or adjusters may not exceed $5,000 per violation. The fine is in addition to all other penalties imposed by the laws of this state and must be collected by the commissioner in the name of the state of Montana. Imposition of a fine under this section is an order from which an appeal may be taken, pursuant to the provisions of 33-1-711.

History: En. Sec. 28, Ch. 286, L. 1959; amd. Sec. 1, Ch. 16, L. 1969; R.C.M. 1947, 40-2709(4); amd. Sec. 1, Ch. 278, L. 1987; amd. Sec. 81, Ch. 370, L. 1987; amd. Sec. 7, Ch. 606, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1, Ch. 164, L. 1993.

Cross-References

Appeal — Lewis and Clark County District Court, 33-1-711.

Offenses without criminal intent — limitation, 45-2-104.

33-1-318. Injunctions and other remedies. (1) Whenever it appears to the commissioner that a person has engaged in or is about to engage in an act or practice constituting a violation of 33-1-501, 33-1-1302, 33-14-201, chapters 2, 16 through 18, and 30 of this title, part 13 of chapter 20 of this title, part 4 of chapter 25 of this title, part 1 of chapter 38 of this title, or any rule or order issued under this code, the commissioner may:

(a) issue an order directing the person to cease and desist from continuing the act or practice after reasonable notice and opportunity for a hearing;

(b) issue a temporary cease and desist order that must remain in effect until 10 days after the hearing is held. If the commissioner issues a temporary cease and desist order, the respondent has 15 days from receipt of the order to make a written request for a hearing on the allegations contained in the order. The hearing must be held within 20 days of the commissioner's receipt of the hearing request unless the time is extended by agreement of the parties. If the respondent does not request a hearing within 15 days of receipt of the order and the commissioner does not order a hearing, the order becomes final.

(c) without the issuance of a cease and desist order, bring an action in a court of competent jurisdiction to enjoin the acts or practices and to enforce compliance with this code or any rule or order issued under this code. Upon a proper showing, a permanent or temporary injunction, restraining order, or writ of mandamus must be granted and a receiver or conservator may be appointed for the defendant or the defendant's assets. The commissioner may not be required to post a bond.

(2) If a hearing is held on a cease and desist order, both parties have 20 days from the date the hearing is concluded or from the date a transcript of the hearing is filed, if one is requested, to submit proposed findings of fact, conclusions of law, orders, and supporting briefs to the hearings examiner. The parties have an additional 10 days within which to submit comments on the opposing party's proposed findings of fact, conclusions of law, orders, and briefs. A final order must be issued within 30 days of the submission of the comments.

(3) The commissioner may, after giving reasonable notice and an opportunity for a hearing under this section, impose a fine not to exceed $5,000 for each violation upon a person found to have engaged in an act or practice constituting a violation of a provision of this code or any rule or order issued under this code. The fine is in addition to all other penalties imposed by the laws of this state and must be collected by the commissioner in the name of the state of Montana and deposited in the general fund. Imposition of a fine under this subsection is an order from which an appeal may be taken pursuant to 33-1-711. If a person fails to pay a fine referred to in this subsection, the amount of the fine is a lien upon all of the assets and property of that person in this state and may be recovered by suit by the commissioner and deposited in the general fund. Failure of the person to pay a fine also constitutes a forfeiture of the right to do business in this state under this code.

History: En. Sec. 1, Ch. 513, L. 1987; amd. Sec. 4, Ch. 493, L. 2003; amd. Sec. 1, Ch. 456, L. 2005.

Part 4
Examinations by Department

33-1-401. Examination of insurers. (1) The commissioner shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer as often as the commissioner considers advisable. The commissioner shall examine each authorized insurer not less frequently than every 5 years.

(2) The commissioner shall in like manner examine each insurer applying for an initial certificate of authority to do business in this state.

(3) In lieu of making an examination under this part of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. After January 1, 1994, the reports may only be accepted if:

(a) the insurance department was at the time of the examination accredited under the national association of insurance commissioners' financial regulation standards and accreditation program; or

(b) the examination is performed under the supervision of an accredited state insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination workpapers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(4) For purposes of completing an examination of any company under this part, the commissioner may examine or investigate any person or the business of any person, insofar as the examination or investigation is, in the sole discretion of the commissioner, necessary or material to the examination of the company.

History: En. Sec. 32, Ch. 286, L. 1959; R.C.M. 1947, 40-2713; amd. Sec. 39, Ch. 596, L. 1993.

Cross-References

Certificates of authority, Title 33, ch. 2, part 1.

33-1-402. Examination of insurance producers, managers, and promoters. For the purpose of ascertaining compliance with this code, the commissioner may, as often as the commissioner considers advisable, examine the accounts, records, documents, and transactions pertaining to or affecting its insurance affairs or proposed insurance affairs of:

(1) an insurance producer, surplus lines insurance producer, general insurance producer, adjuster, or public adjuster;

(2) a person having a contract under which the person enjoys in fact the exclusive or dominant right to manage or control an insurer;

(3) a person holding the shares of voting stock or policyholder proxies of a domestic insurer, for the purpose of controlling the management of the domestic insurer, as voting trustee or otherwise;

(4) a person engaged in or proposing to be engaged in or assisting in the promotion or formation of a domestic insurer or insurance holding corporation or corporation to finance a domestic insurer or the production of its business.

History: En. Sec. 33, Ch. 286, L. 1959; R.C.M. 1947, 40-2714; amd. Sec. 22, Ch. 537, L. 1987; amd. Sec. 7, Ch. 713, L. 1989; amd. Sec. 1064, Ch. 56, L. 2009; amd. Sec. 1, Ch. 139, L. 2015.

33-1-403. Repealed. Sec. 71, Ch. 596, L. 1993.

History: En. Sec. 34, Ch. 286, L. 1959; R.C.M. 1947, 40-2715; amd. Sec. 1, Ch. 713, L. 1989.

33-1-404 through 33-1-407 reserved.

33-1-408. Conduct of examinations — records — correction of accounts — appraisals. (1) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, an examiner shall observe the guidelines and procedures set forth in the examiners' handbook adopted by the NAIC. The commissioner may also employ other guidelines or procedures as the commissioner considers appropriate.

(2) Every company or person from whom information is sought and its officers, directors, employees, and agents shall provide to the examiners appointed under subsection (1) timely, convenient, and free access at all reasonable hours to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined, including but not limited to access at its offices. The officers, directors, employees, and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the examiners is grounds for suspension, refusal, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. A proceeding for suspension, revocation, or refusal of any license or authority must be conducted pursuant to 33-1-318 and 33-1-701.

(3) The commissioner or any examiner has the power to issue subpoenas, administer oaths, and examine under oath any person concerning any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or to produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(4) When making an examination under this part, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of retaining the personnel must be borne by the company that is the subject of the examination.

(5) This part may not be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to this title. Findings of fact and conclusions made pursuant to an examination are prima facie evidence in any legal or regulatory action.

(6) This part may not be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the commissioner may consider appropriate.

History: En. Sec. 31, Ch. 596, L. 1993; amd. Sec. 6, Ch. 380, L. 2003; amd. Sec. 4, Ch. 157, L. 2023.

33-1-409. Examination reports — hearings — confidentiality — publication. (1) All examination reports must be composed only of facts appearing upon the books, records, or other documents of the company, its agents, or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs. The report must contain the conclusions and recommendations that the examiners find reasonably warranted from the facts.

(2) Not later than 60 days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice that gives the company examined a reasonable opportunity, but not more than 30 days, to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's workpapers and enter an order:

(a) adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation.

(b) rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation, information, or testimony and of refiling pursuant to subsection (2); or

(c) calling for an investigatory hearing with no less than 20 days' notice to the company for purposes of obtaining additional data, documentation, information, and testimony.

(4) (a) All orders entered pursuant to subsection (3)(a) must be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner workpapers, and any written submissions or rebuttals. An order must be considered a final administrative decision and may be appealed pursuant to Title 33, chapter 1, part 7, and must be served upon the company by certified mail, together with a copy of the adopted examination report. Within 30 days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(b) (i) A hearing conducted under subsection (3)(c) by the commissioner or an authorized representative must be conducted as a nonadversarial, confidential, investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies, or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant workpapers or by the written submission or rebuttal of the company. Within 20 days of the conclusion of the hearing, the commissioner shall enter an order pursuant to subsection (3)(a).

(ii) The commissioner may not appoint an examiner as an authorized representative to conduct the hearing. The hearing must proceed expeditiously with discovery by the company limited to the examiner's workpapers that tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or the commissioner's representative may issue subpoenas for the attendance of witnesses or the production of documents considered relevant to the investigation, whether under the control of the department, the company, or other persons. The documents produced must be included in the record, and testimony taken by the commissioner or the commissioner's representative must be under oath and preserved for the record. This section does not require the department to disclose any information or records that would indicate or show the existence or content of an investigation or activity of a criminal justice agency.

(iii) The hearing must proceed with the commissioner or the commissioner's representative posing questions to the persons subpoenaed. The company and the department may present testimony relevant to the investigation. Cross-examination may be conducted only by the commissioner or the commissioner's representative. The company and the department must be permitted to make closing statements and may be represented by counsel of their choice.

(5) (a) Upon the adoption of the examination report under subsection (3)(a), the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of 30 days, except to the extent provided in subsection (2). After 30 days, the commissioner shall open the report for public inspection as long as a court of competent jurisdiction has not stayed its publication.

(b) This title does not prevent and may not be construed as prohibiting the commissioner from disclosing the content of an examination report or preliminary examination report, the results of an examination, or any matter relating to a report or results to the insurance department of this state or of any other state or country, to law enforcement officials of this state or of any other state, or to an agency of the federal government at any time as long as the agency or office receiving the report or matters relating to the report agrees in writing to hold it in a manner consistent with this part.

(c) If the commissioner determines that regulatory action is appropriate as a result of an examination, the commissioner may initiate any proceedings or actions as provided by law.

(6) (a) Working papers must be given confidential treatment, are not subject to subpoena, are not discoverable or admissible as evidence in any private action, and may not be made public by the commissioner or any other person except to the extent provided in 33-1-311(5) and subsection (5) of this section. Persons given access to working papers shall agree, prior to receiving the information, to treat the information in the manner required by this section unless prior written consent has been obtained from the company to which the working papers pertain.

(b) For purposes of subsection (6)(a), "working papers" means:

(i) all papers and copies created, produced, obtained by, or disclosed to the commissioner or any other person in the course of an examination or analysis by the commissioner;

(ii) confidential criminal justice information, as defined in 44-5-103;
(iii) personal information protected by an individual privacy interest; and
(iv) specifically identified trade secrets, as defined in 30-14-402, that have been obtained by or disclosed to the commissioner or any other person in the course of an examination made under this part for which there are reasonable grounds of privilege that are asserted by the party claiming the privilege.

History: **En. Sec. 32, Ch. 596, L. 1993; amd. Sec. 6, Ch. 416, L. 1999; amd. Sec. 1, Ch. 169, L. 2013; amd. Sec. 5, Ch. 63, L. 2015; amd. Sec. 10, Ch. 9, L. 2017.**

33-1-410. Conflict of interest. (1) An examiner may not be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest with, is affiliated with the management of, or owns a pecuniary interest in any person subject to examination under this part. This section may not be construed to automatically preclude an examiner from being:
(a) a policyholder or claimant under an insurance policy;
(b) a grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;
(c) an investment owner in shares of regulated diversified investment companies; or
(d) a settlor or beneficiary of a blind trust into which any otherwise impermissible holdings have been placed.

(2) Notwithstanding the requirements of this section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other individuals who are independently practicing their professions, even though the persons may from time to time be similarly employed or retained by persons subject to examination under this part.

History: **En. Sec. 33, Ch. 596, L. 1993.**

33-1-411. Destruction of records — hindrance of examination — penalty. A director, officer, agent, or employee of a company who for the purpose of hindering any examination conducted pursuant to this part destroys any books, records, or documents required to be kept by law shall be punished by a fine as provided in 33-1-317. After notice and hearing in accordance with Title 33, chapter 1, part 7, the commissioner may revoke the certificate of authority of the company.

History: **En. Sec. 35, Ch. 286, L. 1959; amd. Sec. 1, Ch. 28, L. 1967; R.C.M. 1947, 40-2716(3); amd. Sec. 6, Ch. 198, L. 1979; amd. Sec. 11, Ch. 472, L. 1999.**

33-1-412. Repealed. Sec. 71, Ch. 596, L. 1993.

History: **En. Sec. 35, Ch. 286, L. 1959; amd. Sec. 1, Ch. 28, L. 1967; R.C.M. 1947, 40-2716(1), (2), (4) thru (7).**

33-1-413. Examination expense — lien. (1) Upon presentation of a detailed account of charges and expenses by the commissioner or pursuant to the commissioner's written authorization, each person examined, other than examinations pursuant to 33-1-402, shall pay the actual travel expenses, a reasonable living expense allowance, and a per diem as compensation of examiners as necessarily incurred on account of the examination, all at reasonable rates as established or adopted by the commissioner. An account may be presented periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of an examination.

(2) The commissioner shall pay to the state treasurer to the credit of the state special revenue fund all money received pursuant to subsection (1).

(3) If a person fails to pay the charges and expenses, as referred to in subsection (1), the charges and expenses must be paid out of the funds of the commissioner in the same manner as other disbursements of the funds. The amount paid is a first lien upon all of the assets and property in this state of the person and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund.

History: **En. Sec. 36, Ch. 286, L. 1959; amd. Sec. 72, Ch. 147, L. 1963; R.C.M. 1947, 40-2717; amd. Sec. 96, Ch. 379, L. 1995.**

Cross-References

Attorney General — duties, 2-15-501.
Examination of insurance producers, managers, and promoters, 33-1-402.
Liens — definition, 71-3-101.
Ordering of liens, 71-3-115.

Part 5
Approval of Forms

Part Cross-References

Motor club service companies — approval of service contract forms, 61-12-308.

33-1-501. Filing of forms — approval — review of disapproval or withdrawal of approval — application. (1) (a) An insurance policy or annuity contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate may not be delivered or issued for delivery in Montana unless the form and, for the purposes of disability insurance, an outline of coverage as required by 33-22-244 and 33-22-521 have been filed with and approved by the commissioner and, if required, the regulatory official of the state of domicile of the insurer or the interstate insurance product regulation commission provided for in 33-39-101. This provision does not apply to surety bonds or policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine, other than ocean marine and foreign trade coverages, casualty, and surety insurance coverages may be filed by a rating organization on behalf of its members and subscribers or by a member or subscriber on its own behalf.

(b) A filing required by subsection (1)(a) must be submitted by an officer of the insurer with a certification in a form prescribed by the commissioner. The certification must state that to the best of the officer's knowledge and belief, the policy, contract form, certificate, enrollment form, application form, printed rider or endorsement form, or form of renewal certificate complies with the applicable provisions of Title 33.

(c) The approval of an insurance policy or annuity contract form, certificate, enrollment form, application form, or other related insurance form by the state of domicile may be waived by the commissioner if the commissioner considers the requirements of subsection (1)(a) unnecessary for the protection of Montana insurance consumers. If the requirement is waived, an insurer shall notify the commissioner in writing within 10 days of disapproval, denial, or withdrawal of approval of a form by the state of domicile.

(2) (a) The filing must be made not less than 60 days before delivery and must be delivered by hand or sent by certified mail with a return receipt requested. The commissioner's office shall mark a filing with the date of receipt by the commissioner's office.

(b) (i) If after 60 days from the date of receipt by the commissioner's office the commissioner has not approved or disapproved the form by a notice pursuant to the provisions in subsection (4), the form is considered approved for all purposes, subject to subsection (2)(c).

(ii) The running of the 60-day period is tolled for a period commencing on the date that the commissioner notifies the insurer of problems or questions and requests additional information from the insurer concerning a form filed pursuant to subsection (1)(a) and ending on the date that the insurer submits its response to the commissioner.

(iii) For purposes of tolling the 60-day period as provided in subsection (2)(b)(ii), the commissioner's request notification may be made electronically.

(c) In a letter separate from the original filing and delivered by hand or sent by certified mail with return receipt requested, the insurer shall notify the commissioner, at least 10 days before the use of the form in the market, that the insurer believes that:

(i) the form has been or will be considered approved; and

(ii) the insurer will begin marketing the form in Montana.

(d) The commissioner's office shall mark a letter received pursuant to subsection (2)(c) with the date of receipt by the commissioner's office.

(3) Approval of a form by the commissioner constitutes a waiver of any unexpired portion of the waiting period.

(4) The commissioner may at any time, after notice and for cause shown, withdraw any approval. Notice by the commissioner disapproving a form or withdrawing a previous approval must state the grounds for disapproval or withdrawal in sufficient detail to inform the insurer of the specific reason or reasons for and the legal authority supporting the disapproval or

withdrawal of approval in whole or in part. The disapproval or withdrawal of approval does not take effect unless it is issued after the commissioner has reviewed the form and provided notice to the person who filed the form pursuant to 33-1-314 and this subsection.

(5) After the date of the insurer's receipt of notice of disapproval or withdrawal of approval by the commissioner, the insurer may not deliver the form or issue the form for delivery in Montana.

(6) The insurer may request a hearing, as provided for in 33-1-701, for unresolved disputes regarding a disapproval or a withdrawal of approval.

(7) The commissioner may exempt from the requirements of this section, for so long as the commissioner considers proper, an insurance document, form, or type of document or form to which, in the commissioner's opinion, this section may not practicably be applied or the filing and approval of which are not desirable or necessary for the protection of the public.

(8) This section applies to a form used by a domestic insurer for delivery in a jurisdiction outside Montana if the insurance supervisory official of the jurisdiction informs the commissioner that the form is not subject to approval or disapproval by the official and upon the commissioner's order requiring the form to be submitted to the commissioner for the purpose. The same standards apply to these forms as apply to forms for domestic use.

(9) Section 33-1-502 and this section do not apply to:

(a) reinsurance;

(b) policies or contracts not issued for delivery in Montana or delivered in Montana, except as provided in subsection (8);

(c) ocean marine and foreign trade insurances.

(10) Except as provided in chapter 21, group certificates that are delivered or issued for delivery in Montana for group insurance policies effectuated and delivered outside Montana but covering persons resident in Montana must be filed with the commissioner. The certificates must meet the minimum provisions mandated by Montana if Montana law prevails over conflicting provisions of other state law.

History: En. Secs. 258, 271, Ch. 286, L. 1959; R.C.M. 1947, 40-3701(part), 40-3714; amd. Sec. 1, Ch. 303, L. 1981; amd. Sec. 1, Ch. 518, L. 1983; amd. Sec. 1, Ch. 156, L. 1989; amd. Sec. 2, Ch. 451, L. 1993; amd. Sec. 6, Ch. 379, L. 1995; amd. Sec. 1, Ch. 295, L. 2001; amd. Sec. 1, Ch. 336, L. 2001; amd. Sec. 1, Ch. 409, L. 2005; amd. Sec. 5, Ch. 360, L. 2013; amd. Sec. 8, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 8, Ch. 8, L. 2025. Amendment effective October 1, 2025.

Cross-References

Rating organization — definition, 33-16-102.

33-1-502. Grounds for disapproval. The commissioner shall disapprove any form filed under 33-1-501 or withdraw any previous approval of a form only if the form:

(1) is in any respect in violation of or does not comply with the laws of this state;

(2) contains or incorporates by reference, where the incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions that deceptively affect the risk purported to be assumed in the general coverage of the contract, including a provision in a casualty insurance form permitting defense costs within limits, except as permitted by the commissioner;

(3) has any title, heading, or other indication of its provisions that is misleading;

(4) is printed or otherwise reproduced in a manner that renders any provision of the form substantially illegible;

(5) contains any provision that violates the provisions of 49-2-309.

History: En. Sec. 272, Ch. 286, L. 1959; R.C.M. 1947, 40-3715; amd. Sec. 1, Ch. 122, L. 1987; amd. Sec. 10, Ch. 699, L. 1991; amd. Sec. 1065, Ch. 56, L. 2009; amd. Sec. 8, Ch. 151, L. 2017.

Cross-References

Plain Language in Contracts Act, Title 30, ch. 14, part 11.

Language simplification requirements, 33-15-321 through 33-15-329.

Part 6
Service of Process

33-1-601. Repealed. Sec. 14, Ch. 60, L. 2019.

History: En. Sec. 63, Ch. 286, L. 1959; R.C.M. 1947, 40-2818(1), (3); amd. Sec. 19, Ch. 227, L. 2001; amd. Sec. 1, Ch. 271, L. 2009.

33-1-602. Repealed. Sec. 14, Ch. 60, L. 2019.

History: En. Sec. 63, Ch. 286, L. 1959; R.C.M. 1947, 40-2818(2); amd. Sec. 1066, Ch. 56, L. 2009.

33-1-603. Repealed. Sec. 14, Ch. 60, L. 2019.

History: En. Sec. 64, Ch. 286, L. 1959; amd. Sec. 1, Ch. 321, L. 1977; R.C.M. 1947, 40-2819; amd. Sec. 1067, Ch. 56, L. 2009.

33-1-604. Service of process — domestic insurer. (1) Service of process against a domestic insurer must be made pursuant to 35-7-113 or in any other manner permitted by law.

(2) Service of process against a domestic reciprocal insurer must be on the attorney-in-fact or in any other manner permitted by law.

History: En. Sec. 1, Ch. 60, L. 2019.

33-1-605. Service of process — foreign or alien insurer — appointment of registered agent. (1) A foreign or alien insurer that transacts any business in this state must have a registered agent upon whom any legal process, notice, or demand required or permitted by law to be served upon a company must be served. The agent must be a person who either resides or maintains a business address in this state.

(2) The written appointment of an agent must be provided to the commissioner in a form prescribed by the commissioner, and must, at minimum, include a consent to service of process and the official name and address of the agent and the insurer represented.

(3) The commissioner shall keep a record of the foreign and alien insurers transacting business in Montana and the name and address of their registered agents. This record must be made public in a readily accessible form prescribed by the commissioner.

(4) Service by certified mail to a registered agent listed for an insurer constitutes service of legal process upon that insurer.

(5) An insurer may revoke the appointment of an agent by filing with the commissioner a written appointment of another agent and a statement that the appointment of the former agent is revoked. The authority of the agent whose appointment has been revoked terminates 30 days after the notice is received by the commissioner.

(6) When a foreign or alien insurer ceases to do business in this state, the agent last designated by or acting for the insurer is deemed to continue as agent for it unless a new agent is appointed. Service by certified mail upon any such agent constitutes service of legal process upon the insurer.

(7) This section does not limit or affect the right to serve any process, notice, or demand upon an insurer in any other manner permitted by law.

(8) When legal process is served pursuant to this section, the insurer must appear, answer, or plead within 30 days, exclusive of the date of mailing, after the date of the certified mailing or be subject to the laws of this state regarding default judgment.

(9) For the purposes of this section:

(a) "certified mail" means a method of sending by common carrier with tracking capability; and

(b) "legal process" means a summons and complaint.

History: En. Sec. 2, Ch. 60, L. 2019; amd. Sec. 5, Ch. 157, L. 2023.

33-1-606. Service of process by commissioner. (1) If a registered agent cannot be found for a foreign or alien insurer doing business in this state, if the agent of record is no longer at the agent's listed address, if the insurer has failed to maintain an agent as required by 33-1-605, or for other good cause shown for which a person's rights may be adversely affected by inability to serve an insurer, a person desiring to serve legal process, notice, or demand may initiate service on the commissioner by providing to the commissioner all of the following:

(a) an affidavit stating that one of the conditions in subsection (1) exists and stating the most recent address of the insurer that the person, after diligent search, has been able to ascertain;

(b) two copies of the document to be served on the insurer; and

(c) a filing fee of $50.

(2) If the requirements of subsection (1) have been met, the commissioner shall promptly serve the legal process, notice, or demand by certified mail to the foreign or alien insurer at its principal office as shown in the commissioner's records. Service by the commissioner upon the insurer by certified mail constitutes service of legal process on that insurer. The commissioner shall maintain a record of each process, notice, or demand the commissioner serves under this section.

(3) When legal process is served pursuant to this section, the insurer must appear, answer, or plead within 30 days, exclusive of the date of mailing, after the date of the certified mailing or be subject to the laws of this state regarding default judgment.

(4) For purposes of this section:

(a) "certified mail" means a method of sending by common carrier with tracking capability; and

(b) "legal process" means a summons and complaint.

History: **En. Sec. 3, Ch. 60, L. 2019.**

33-1-607 through 33-1-610 reserved.

33-1-611. Unauthorized Insurers Process Act — interpretation. (1) Sections 33-1-611 through 33-1-616 constitute and may be cited as the "Unauthorized Insurers Process Act".

(2) Such act shall be so interpreted as to effectuate its general purpose to make uniform the law of those states which enact it.

History: **En. Sec. 178, Ch. 286, L. 1959; R.C.M. 1947, 40-3403.**

Cross-References

Suits by unauthorized insurers prohibited, 33-2-105.

Actions against insurer — venue — service of process, 33-2-314.

33-1-612. Commissioner — process agent for unauthorized insurer doing business in state. Delivery, effectuation, or solicitation of any insurance contract, by mail or otherwise, within this state by an unauthorized insurer or the performance within this state of any other service or transaction connected with the insurance by or on behalf of the insurer must be considered to constitute an appointment by the insurer of the commissioner and the commissioner's successors in office as its attorney, upon whom may be served all lawful process issued within this state in any action or proceeding against the insurer arising out of any contract or transaction and must be considered to signify the insurer's agreement that any service of process has the same legal effect and validity as personal service of process upon it in this state.

History: **En. Sec. 179, Ch. 286, L. 1959; R.C.M. 1947, 40-3404; amd. Sec. 1068, Ch. 56, L. 2009.**

33-1-613. Service of process — criteria mandating designation of commissioner. (1) Service of process upon any insurer pursuant to 33-1-612 must be made by delivering to and leaving with the commissioner or some person in apparent charge of the commissioner's office two copies of the process and the payment to the commissioner of the same fee as provided in 33-1-606. The commissioner shall mail by certified mail one of the copies of the process to the defendant at its principal place of business last known to the commissioner and shall keep a record of any process served upon the commissioner. The service of process is sufficient if notice of the service and a copy of the process are sent within 10 days by certified mail by the plaintiff's attorney to the defendant at its last-known principal place of business and the defendant's receipt or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance with this section are filed with the clerk of the court in which the action is pending on or before the date the defendant is required to appear or within further time that the court may allow.

(2) Service of process in any action, suit, or proceeding must in addition to the manner provided in subsection (1) be valid if:

(a) served upon any person within this state who in this state on behalf of the insurer is:

(i) soliciting insurance;

(ii) making any contract of insurance or issuing or delivering any policies or written contracts of insurance; or

(iii) collecting or receiving any premium for insurance;

(b) a copy of the process is sent within 10 days by certified mail by the plaintiff's attorney to the defendant at the last-known principal place of business of the defendant; and

(c) the defendant's receipt or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff's attorney showing a compliance with this section are filed with the clerk of the court in which the action is pending on or before the date the defendant is required to appear or within further time that the court may allow.

(3) A plaintiff or complainant may not be entitled to a judgment by default under this section until the expiration of 30 days from the date of the filing of the affidavit of compliance.

(4) This section does not limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner now or later permitted by law.

History: En. 40-3405 by Sec. 180, Ch. 286, L. 1975; R.C.M. 1947, 40-3405; amd. Sec. 1069, Ch. 56, L. 2009; amd. Sec. 4, Ch. 60, L. 2019.

Cross-References

Fee for Commissioner's service of process, 33-1-606.

33-1-614. Exemptions from service of process provisions. Sections 33-1-611 through 33-1-613 shall not apply to:

(1) surplus lines insurance lawfully effectuated under part 3, chapter 2;

(2) reinsurance; or

(3) any action or proceeding against an unauthorized insurer arising out of:

(a) wet marine and transportation insurance;

(b) insurance on or with respect to subjects located, resident, or to be performed wholly outside this state or on or with respect to vehicles or aircraft owned and principally garaged outside this state;

(c) insurance on property or operations of railroads engaged in interstate commerce; or

(d) insurance on aircraft or cargo of such aircraft or against liability, other than employer's liability, arising out of the ownership, maintenance, or use of such aircraft, where the policy or contract contains a provision designating the commissioner as its attorney for the acceptance of service of lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such policy or where the insurer enters a general appearance in any such action.

History: En. Sec. 181, Ch. 286, L. 1959; R.C.M. 1947, 40-3406; amd. Sec. 23, Ch. 537, L. 1987.

33-1-615. Defense of action by unauthorized insurer. (1) Before an unauthorized insurer shall file or cause to be filed any pleading in any action or proceeding instituted against it under 33-1-612 and 33-1-613, such insurer shall:

(a) procure a certificate of authority to transact insurance in this state; or

(b) deposit with the clerk of the court in which such action or proceeding is pending cash or securities or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such action. The court may in its discretion make an order dispensing with such deposit or bond where the insurer makes a showing satisfactory to the court that it maintains in a state of the United States funds or securities, in trust or otherwise, sufficient and available to satisfy any final judgment which may be entered in such action or proceeding and that the insurer will pay any final judgment entered therein without requiring suit to be brought on such judgment in the state where such funds or securities are located.

(2) The court in any action or proceeding in which service is made in the manner provided in 33-1-613 may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (1) above and to defend such action.

(3) Nothing in subsection (1) above is to be construed to prevent an unauthorized insurer from filing a motion to quash or to set aside the service of any process made in the manner provided in 33-1-613 hereof, on the ground either:

(a) that such unauthorized insurer has not done any of the acts enumerated in 33-1-612; or

(b) that the person on whom service was made pursuant to 33-1-613(2) was not doing any of the acts therein enumerated.

History: **En. Sec. 182, Ch. 286, L. 1959; R.C.M. 1947, 40-3407.**

33-1-616. Attorney's fee. In any action against an unauthorized insurer under this Unauthorized Insurers Process Act, if the insurer has failed for 30 days after demand prior to the commencement of the action to make payment in accordance with the terms of the insurance contract and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney's fee and include such fee in any judgment that may be rendered in such action. The fee shall not exceed one-third of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer, but in no event shall such fee be less than $100. Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

History: **En. Sec. 183, Ch. 286, L. 1959; R.C.M. 1947, 40-3408.**

Cross-References

Attorney fees, 25-10-301.

Factual basis for punitive or exemplary damages, 27-1-220.

Part 7
Hearings and Appeals

Part Cross-References

Contested cases — Montana Administrative Procedure Act, Title 2, ch. 4, part 6.

33-1-701. Hearings — discretion — written demand — procedure. (1) The commissioner may hold hearings for any purpose within the scope of this code considered necessary. Hearing procedures contained in Title 33, chapter 1, apply only to Title 33, except as otherwise provided.

(2) A person may provide the commissioner with a written demand for a hearing. A written demand must specify the grounds relied upon as a basis for the relief sought at the hearing. If the commissioner does not issue an order granting a person's request for a hearing within 30 days of receiving a request, the hearing is considered refused.

(3) All hearings must be conducted pursuant to the Montana Administrative Procedure Act, as provided in Title 2, chapter 4, part 6. Any supplemental hearing procedures may be adopted by administrative rule.

History: **En. Sec. 39, Ch. 286, L. 1959; R.C.M. 1947, 40-2720; amd. Sec. 1, Ch. 331, L. 1999; amd. Sec. 20, Ch. 227, L. 2001; amd. Sec. 6, Ch. 63, L. 2015.**

Cross-References

Contested administrative proceeding — notice requirements, 2-4-601.

33-1-702. Repealed. Sec. 73, Ch. 227, L. 2001.

History: **En. Sec. 40, Ch. 286, L. 1959; R.C.M. 1947, 40-2721.**

33-1-703. Repealed. Sec. 73, Ch. 227, L. 2001.

History: **En. Sec. 41, Ch. 286, L. 1959; R.C.M. 1947, 40-2722.**

33-1-704. Repealed. Sec. 73, Ch. 227, L. 2001.

History: **En. Sec. 42, Ch. 286, L. 1959; R.C.M. 1947, 40-2723(1) thru (5); amd. Sec. 7, Ch. 198, L. 1979; amd. Sec. 32, Ch. 457, L. 1987; amd. Sec. 32, Ch. 798, L. 1991.**

33-1-705. Rehearing. Upon written request of a party to a hearing filed with the commissioner within 30 days after any order made pursuant to the hearing has been mailed or delivered to the persons entitled to receive the order, the commissioner may grant a rehearing or reargument of the matters involved in the hearing.

History: **En. Sec. 42, Ch. 286, L. 1959; R.C.M. 1947, 40-2723(6); amd. Sec. 7, Ch. 380, L. 2003.**

33-1-706. Repealed. Sec. 73, Ch. 227, L. 2001.
History: **En. Sec. 43, Ch. 286, L. 1959; R.C.M. 1947, 40-2724.**

33-1-707. Administrative or civil action — statute of limitations. (1) Unless otherwise provided by law, the department shall commence an administrative or civil action for a violation of the insurance code within 2 years of the date of the violation or within 2 years after the department discovers the violation or, through the use of reasonable diligence, should have discovered the violation, whichever occurs later.

(2) Regardless of when the department discovers a violation or should have discovered a violation through the use of reasonable diligence, the department may not commence an administrative or civil action unless it is brought within 5 years of the date of the violation.
History: **En. Sec. 4, Ch. 227, L. 2001; amd. Sec. 13, Ch. 396, L. 2017.**

33-1-708 through 33-1-710 reserved.

33-1-711. Appeals of commissioner's order — stays — exceptions. (1) Except as provided in subsection (2), an appeal of the commissioner's order must be filed with the district court in Lewis and Clark County pursuant to the procedures provided for in Title 2, chapter 4, part 7.

(2) Appeals from the suspension or revocation of the certificate of authority of a domestic insurer or of the license of an insurance producer or surplus lines insurance producer may be filed in the district court of the county of Montana that the insurer or producer has its principal place of business or the licensee resides.

(3) Any request for a stay of the commissioner's order must be made within 30 days of filing an appeal in district court.

(4) Costs must be awarded as in civil actions.

(5) This section does not apply to appeals for matters covered by Title 33, chapter 16.
History: **En. Sec. 44, Ch. 286, L. 1959; R.C.M. 1947, 40-2725; amd. Sec. 1, Ch. 119, L. 1987; amd. Sec. 24, Ch. 537, L. 1987; amd. Sec. 8, Ch. 713, L. 1989; amd. Sec. 1, Ch. 798, L. 1991; amd. Sec. 21, Ch. 227, L. 2001.**

Cross-References
Costs in civil actions, Title 25, ch. 10.

Part 8
Interference With Medical Communications

33-1-801. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Enrollee" means the individual to whom a health care service is provided or will be provided under a health plan.

(2) "Health care provider" or "provider" means a health care professional or facility.

(3) "Health carrier" means an entity that is subject to the insurance laws and rules of this state and that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term includes a disability insurer, health maintenance organization, or a health service corporation or other entity providing a health benefit plan.

(4) "Health plan" or "health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) "Managed care organization" means an entity that manages, owns, contracts with, or employs health care providers to provide health care services under a health plan. The term includes a health maintenance organization, as defined in 33-31-102, and an entity that does not itself provide health plans.

(6) "Medical communication" means:

(a) a communication made by a health care provider to an enrollee or to the guardian or other legal representative of an enrollee receiving health care services from the provider:

(i) concerning the mental or physical health care needs or treatment of the enrollee and the provisions, terms, or requirements of the health plan or another health plan relating to the needs or treatment of the enrollee; and

(ii) including a communication concerning:

(A) a test, consultation, or treatment option and a risk or benefit associated with the test, consultation, or option;

(B) variation among health care providers and health care facilities, as defined in 50-5-101, in experience, quality of health care services, or health outcomes;

(C) the basis or standard for the decision of the enrollee's health carrier or managed care organization to authorize or deny a health care service;

(D) the process used by the enrollee's health carrier or managed care organization to determine whether to authorize or deny a health care service; or

(E) a financial incentive or disincentive provided by the enrollee's health carrier or managed care organization to a health care provider to authorize or deny a health care service;

(b) a communication made by a health care provider to another health care provider, an employee or contractor of the enrollee's managed care organization, or an employee of the health carrier advocating a particular method of treatment on behalf of an enrollee.

History: **En. Sec. 2, Ch. 527, L. 1997.**

33-1-802. Gag clauses and other action affecting medical communications prohibited — exceptions. (1) A health carrier or managed care organization may not by an oral or written contract, by an oral or written direction or requirement, or by a financial inducement or penalty prohibit a provider from making or interfere with a provider making a medical communication to an enrollee. A contract, direction, requirement, or financial inducement or penalty violating this subsection is void.

(2) Subsection (1) does not apply to:

(a) an oral or written contract, direction, requirement, or financial inducement or penalty prohibiting a provider from disclosing a trade secret, as defined in 30-14-402, to the same extent as other employees or contractors of the health carrier or managed care organization are prohibited from disclosing the trade secret;

(b) an oral or written contract, direction, requirement, or financial inducement or penalty prohibiting a health care provider from referring an enrollee to another health plan or managed care organization in which the provider making the referral has a direct financial interest; and

(c) the terms of an oral or written contract mutually agreed upon by a health carrier or managed care organization and a provider requiring the provider to participate in and cooperate with all programs, policies, and procedures implemented by the health carrier or managed care organization to ensure, review, or improve the quality of health care.

History: **En. Sec. 3, Ch. 527, L. 1997.**

33-1-803. Sanction because of medical communication prohibited. A health carrier or managed care organization may not take any of the following actions with regard to a health care provider because the provider made a medical communication to an enrollee or to the guardian or legal representative of the enrollee:

(1) terminate an agreement between the health carrier or managed care organization and the health care provider to provide health care services;

(2) reduce compensation to the provider;

(3) demote the provider in regard to relative seniority within the managed care organization;

(4) transfer the provider to other duties within the managed care organization;

(5) deny the provider admitting or other privileges; or

(6) take other action against the provider in retaliation for a medical communication made by the provider to an enrollee.

History: **En. Sec. 4, Ch. 527, L. 1997.**

33-1-804. Civil penalty — civil action for collection of penalty. (1) A health carrier or a managed care organization violating 33-1-802 or 33-1-803 is subject to a civil penalty, as provided in 33-1-317, for each violation. Each day of violation constitutes a separate violation for the purposes of this section.

(2) In addition to other enforcement methods provided by law, the commissioner may bring a civil action in the district court in the county in which the violation occurred to collect the civil penalty provided for in subsection (1) from a person violating a provision of this part.

If the violation occurred in more than one county, any county in which the violation occurred is a proper venue for a civil action. An amount collected by the commissioner pursuant to this section must be deposited in the general fund.

History: **En. Sec. 5, Ch. 527, L. 1997; amd. Sec. 15, Ch. 535, L. 2021.**

Parts 9 and 10 reserved

Part 11

Jurisdiction of Providers of Health Care Benefits

Part Cross-References

Health service corporations, Title 33, ch. 30.

33-1-1101. Short title. This part may be cited as the "Jurisdiction to Determine Jurisdiction of Providers of Health Care Benefits Act".

History: **En. Sec. 1, Ch. 497, L. 1983.**

33-1-1102. Authority and jurisdiction of insurance department. Notwithstanding any other provision of law and except as provided in this part, any person or other entity that provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech-language pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, is presumed to be subject to the jurisdiction of the department unless the person or other entity shows that while providing such services it is subject to the jurisdiction of another agency of this or another state or any subdivision thereof or the federal government.

History: **En. Sec. 2, Ch. 497, L. 1983; amd. Sec. 6, Ch. 413, L. 1989.**

33-1-1103 through 33-1-1110 reserved.

33-1-1111. How to show jurisdiction. A person or entity may show that it is subject to the jurisdiction of another agency of this or another state or any subdivision of this state or another state or the federal government by providing the commissioner with the appropriate certificate, license, or other document issued by the other governmental agency that permits or qualifies it to provide those services. If it is not the practice of the governmental agency to issue a certificate, license, or other document establishing that the agency permits the person or entity to provide those services, the person or entity may show that it is subject to the jurisdiction of the agency by other means appropriate under the circumstances.

History: **En. Sec. 3, Ch. 497, L. 1983; amd. Sec. 16, Ch. 420, L. 1995.**

Cross-References

Regulation of medicine, Title 37, ch. 3.
Regulation of dentistry and dental hygiene, Title 37, ch. 4.
Regulation of optometry, Title 37, ch. 10.
Regulation of physical therapy, Title 37, ch. 11.
Regulation of practice of chiropractic, Title 37, ch. 12.
Regulation of speech-language pathologists and audiologists, Title 37, ch. 15.
Regulation of psychologists, Title 37, ch. 17.
Regulation of denturitry, Title 37, ch. 29.

33-1-1112. Subject to state laws. A person or entity unable to show that it is subject to the jurisdiction of another agency of this or another state or any subdivision thereof or the federal government is subject to all appropriate provisions of this code regarding the conduct of its business.

History: **En. Sec. 5, Ch. 497, L. 1983.**

33-1-1113. Examination. A person or entity which is unable to show under 33-1-1111 that it is subject to the jurisdiction of another agency of this or another state or a subdivision thereof or the federal government must submit to an examination by the commissioner to determine the organization and solvency of the person or entity and to determine whether or not such person or entity complies with the applicable provisions of this code.

History: **En. Sec. 4, Ch. 497, L. 1983.**

33-1-1114. Disclosure. (1) A production agency or administrator that advertises, sells, transacts, or administers the coverage in this state described in 33-1-1102 and that is required to submit to an examination by the insurance commissioner under 33-1-1113 shall, if such coverage is not fully insured or otherwise fully covered by an admitted life or disability insurer or nonprofit health service corporation, advise every purchaser, prospective purchaser, and covered person of such lack of insurance or other coverage.

(2) An administrator that advertises or administers the coverage in this state described in 33-1-1102 and is required to submit to an examination by the commissioner under 33-1-1113 shall advise any production agency of the elements of the coverage, including the amount of "stop-loss" insurance in effect.

History: **En. Sec. 6, Ch. 497, L. 1983.**

Part 12
Insurance Fraud Protection

33-1-1201. Short title — purpose. (1) This part may be cited as the "Insurance Fraud Protection Act".

(2) The purpose of this part is to facilitate the detection of insurance fraud and reduce the occurrence of insurance fraud through the development of fraud prevention programs, improved investigative and prosecutorial services, and increased consumer awareness.

History: **En. Sec. 1, Ch. 237, L. 1995.**

33-1-1202. Administrative or civil insurance fraud. A person commits the act of administrative or civil insurance fraud when the person:

(1) for the purpose of obtaining any money or benefit, presents or causes to be presented to any insurer, purported insurer, producer, or administrator, as defined in 33-17-102, any written or oral statement, including computer-generated documents, containing false, incomplete, or misleading information concerning any fact or thing material to, as part of, or in support of a claim for payment or other benefit pursuant to an insurance policy;

(2) assists, abets, solicits, or conspires with another to prepare or make any written or oral statement containing false, incomplete, or misleading information concerning any fact that is intended to be presented to any insurer or purported insurer or in connection with, material to, or in support of any claim for payment or other benefit pursuant to an insurance policy or contract;

(3) presents or causes to be presented to or by an insurer, purported insurer, producer, or administrator, as defined in 33-17-102, a materially false or altered application of insurance;

(4) accepts premium money knowing that coverage will not be provided;

(5) as a health care provider, submits a false or altered bill or report of physical condition to an insurer;

(6) offers or accepts a direct or indirect inducement to file a false statement of claim with the intent of deceiving an insurer; or

(7) presents or causes to be presented counterfeit insurance documents to any person.

History: **En. Sec. 2, Ch. 237, L. 1995; amd. Sec. 8, Ch. 380, L. 2003; amd. Sec. 2, Ch. 169, L. 2013; amd. Sec. 14, Ch. 396, L. 2017.**

33-1-1203. Powers and duties of commissioner — confidentiality of documents. (1) The commissioner may:

(a) initiate independent inquiries and conduct independent investigations when the commissioner has reason to believe that insurance fraud may be, has been, or is currently being committed;

(b) respond to notice or complaints generated by federal, state, county, and local law enforcement officers, other entities with law enforcement responsibilities, or governmental agencies or units;

(c) review and respond to notices or reports of insurance fraud submitted by any person, select the incidents of suspected fraud that in the commissioner's judgment require further and more detailed investigation, and conduct the investigations;

(d) conduct independent examinations of insurance fraud to determine the extent of insurance fraud, deceit, or intentional misrepresentation;

(e) after investigation, report any meritorious alleged violation of the law to the appropriate prosecuting authority or licensing agencies; and

(f) assemble evidence, prepare charges, and prosecute, if requested, or otherwise assist any prosecuting authority that has jurisdiction, including the attorney general.

(2) Papers, records, documents, reports, materials, or other evidence relative to the subject of an insurance fraud investigation must remain confidential and must be treated as confidential criminal justice information as defined in 44-5-103. Evidence procured pursuant to this section may not be disseminated, except as provided in 44-5-303.

(3) The commissioner shall notify the person who or the entity that has given notice of an alleged insurance fraud pursuant to 33-1-1205(2) of receipt of the notice by the commissioner and of the disposition of the notice and any resulting investigation.

History: **En. Sec. 3, Ch. 237, L. 1995.**

33-1-1204. Cooperation with law enforcement, licensing authorities, and other fraud agencies. (1) The commissioner shall cooperate with law enforcement authorities and all other authorized agencies and related insurance and professional licensing boards of this and other states. As used in this section, the term "authorized agencies" means:

(a) the attorney general of the state of Montana;

(b) the prosecuting attorney responsible for prosecution;

(c) the department of insurance of other jurisdictions;

(d) the United States attorney's office when that office is charged with investigation of the fraud; or

(e) the federal bureau of investigation or any other federal agency charged with investigation of the fraud.

(2) The commissioner shall cooperate to the extent allowed by law with insurance fraud investigators, related organizations of this and other states, and insurance commissioners of other states.

(3) If the commissioner determines that sufficient evidence of the commission of an act of insurance fraud exists, the commissioner shall inform the appropriate prosecuting authority and professional licensing boards.

History: **En. Sec. 4, Ch. 237, L. 1995.**

33-1-1205. Duties of authorized insurers, adjusters, administrators, consultants, and producers — notice exception. (1) Each insurer, independent adjuster, independent administrator, independent consultant, and independent producer shall cooperate fully with the commissioner with respect to the provisions of this part.

(2) Except as provided in subsection (4), an insurer, an officer, or an employee of the insurer, an independent adjuster, an independent administrator, an independent consultant, or an independent producer who has reason to believe that an insurance fraud has been or is being committed shall provide notice of the alleged insurance fraud to the commissioner within 60 days. A producer of an insurer who has reason to believe that an insurance fraud has been or is being committed shall report the alleged fraud to the insurer within 60 days of discovery of the alleged insurance fraud. The insurer shall review the report. If the insurer determines that there is reasonable likelihood that fraud has occurred, the insurer shall forward the report to the commissioner within 30 days of receipt of the report.

(3) Notice to the commissioner by an insurer who has reason to believe that an insurance fraud has been committed in connection with an insurance claim, application, or policy tolls any applicable time period, for the commissioner, in any applicable insurance statute or related insurance regulation, or any applicable provisions of Title 33, chapter 1, part 15, and tolls any time period arising under 33-18-232 or 33-18-242 regarding unfair claims settlement practices.

(4) Notice of an alleged insurance fraud involving an insurance claim or application submitted to the state compensation insurance fund or a policy issued by the state compensation insurance fund must be made within 60 days to the fraud detection and prevention unit established pursuant to 39-71-211.

History: **En. Sec. 5, Ch. 237, L. 1995; amd. Sec. 4, Ch. 276, L. 1997; amd. Sec. 2, Ch. 531, L. 1997; amd. Sec. 15, Ch. 396, L. 2017.**

33-1-1206. Persons not connected with insurance industry — reward fund. (1) Any person who has knowledge of or who believes that an act of insurance fraud is being or has been committed may provide the commissioner with a report or information pertinent to the knowledge and belief and may provide additional information that the commissioner requests.

(2) The commissioner, in cooperation with authorized insurers, producers, and other interested parties, may establish a fund to reward persons who are not connected with the insurance industry and who provide information or furnish evidence leading to the arrest and conviction of persons responsible for insurance fraud. Participation in the fund must be purely voluntary. The books and records of the fund must be open and subject to review by the legislative auditor.

History: En. Sec. 6, Ch. 237, L. 1995.

33-1-1207 through 33-1-1209 reserved.

33-1-1210. Immunity from liability. (1) In the absence of malice, an insurer, an officer, employee, or producer of the insurer, an independent adjuster, an administrator, a consultant, or any private person is not subject to civil liability for filing reports, providing information, or otherwise cooperating with an investigation or examination of insurance fraud conducted by the commissioner.

(2) A person listed in subsection (1) receives immunity if the person:

(a) cooperates with, furnishes evidence to, or provides information regarding any suspected insurance fraud to the commissioner, the national association of insurance commissioners, any nonprofit organization established to detect and prevent insurance fraud, or other insurer or producer; or

(b) complies with an order issued by a court of competent jurisdiction acting in response to a request by the commissioner to furnish evidence or provide testimony.

History: En. Sec. 7, Ch. 237, L. 1995.

33-1-1211. Administrative or civil penalties. (1) If, after a hearing conducted under 33-1-701, the commissioner determines that a person has committed administrative or civil insurance fraud, the commissioner may:

(a) impose any penalty provided for in 33-1-317; or

(b) require the person to pay the costs of the proceeding.

(2) In addition to any other penalties, the commissioner shall require a person who commits administrative or civil insurance fraud to make restitution to the insurer or to any other person for all financial loss sustained as a result of the insurance fraud.

History: En. Sec. 8, Ch. 237, L. 1995; amd. Sec. 16, Ch. 396, L. 2017.

Part 13
Insurer Insurance Fraud Protection

33-1-1301. Insurance, viatical settlement, medical care discount card, pharmacy discount card, and securities fraud education and prevention program — definitions. (1) The commissioner may:

(a) establish an insurance, viatical settlement, medical care discount card, pharmacy discount card, and securities fraud education and prevention program; and

(b) conduct investigations of insurance, viatical settlement, medical care discount card, pharmacy discount card, and securities fraud.

(2) As used in this part:

(a) "medical care discount card" and "pharmacy discount card" have the meanings provided in 33-38-102; and

(b) "viatical settlement broker", "viatical settlement contract", and "viatical settlement provider" have the meanings provided in 33-20-1302.

History: En. Sec. 1, Ch. 390, L. 1997; amd. Sec. 2, Ch. 456, L. 2005; amd. Sec. 1, Ch. 272, L. 2009.

33-1-1302. Insurance, viatical settlement, medical care discount card, and pharmacy discount card administrative or civil fraud — insurer. (1) A person commits the act of insurance, viatical settlement, medical care discount card, or pharmacy discount card fraud when:

(a) in the course of offering or selling insurance, a medical care discount card, or a pharmacy discount card, the person misrepresents a material fact, known to the person to be untrue or made with reckless indifference as to whether it is true, with the intention of causing another person to rely upon the misrepresentation to that relying person's detriment; or

(b) with respect to a viatical settlement, the person violates the provisions of 33-1-1304.

(2) A person commits the act of insurance fraud or viatical settlement fraud by engaging in any transaction, act, practice, course of business, or course of dealing that involves a violation of insurable interest laws.

(3) The commissioner may, after having conducted a hearing pursuant to 33-1-701, impose the penalties provided for in 33-1-317 for a violation of 33-1-1304 or this section. Failure to pay a fine under this section results in a lien upon the assets and property of the person as provided in 33-1-318(3).

(4) In addition to any penalty provided for in 33-1-317, the commissioner may require a person regulated under this title who commits insurance, viatical settlement, medical care discount card, or pharmacy discount card fraud to make full restitution to the victim for all financial losses sustained as a result of the fraud with interest of 10% a year from the date of the fraud plus any costs and reasonable attorney fees, less the amount of any income, refund, or other benefit received by the victim from the insurance, viatical settlement, medical care discount card, or pharmacy discount card.

(5) The commissioner may require a person who commits a violation of this part to make full restitution to any person who may have sustained any losses as a result of the fraud with interest from the date of the loss plus any costs and reasonable attorney fees. The interest rate must be calculated as of the date of the order pursuant to 25-9-205.

(6) An insurer, insurance producer, or other person who sustained any losses and who was awarded restitution may bring suit to recover those sums, including any attorney fees, interest at the rate provided in 25-9-205, and costs incurred in obtaining a judgment.

(7) Failure of a person to pay any amount ordered under this section constitutes a forfeiture of the right to do business in this state.

History: **En. Sec. 2, Ch. 390, L. 1997; amd. Sec. 3, Ch. 456, L. 2005; amd. Sec. 33, Ch. 44, L. 2007; amd. Sec. 2, Ch. 272, L. 2009; amd. Sec. 17, Ch. 396, L. 2017; amd. Sec. 3, Ch. 62, L. 2019.**

33-1-1303. Reporting requirements. (1) An insurer, insurance producer, or other person who has reason to believe that insurance, viatical settlement, medical care discount card, or pharmacy discount card fraud has occurred shall report the suspected fraud to the commissioner or to the insurance producer's or other person's insurer within 60 days of discovery of the occurrence. An insurer shall review a report given to the insurer, and if the insurer determines that there is a reasonable likelihood that fraud has occurred the insurer shall forward the report to the commissioner within 30 days of receipt.

(2) In the absence of malice, an insurer, insurance producer, or other person may not be subjected to civil liability for reporting or providing information or otherwise cooperating with an investigation of insurance, viatical settlement, medical care discount card, or pharmacy discount card fraud.

History: **En. Sec. 3, Ch. 390, L. 1997; amd. Sec. 34, Ch. 44, L. 2007; amd. Sec. 4, Ch. 272, L. 2009.**

33-1-1304. Viatical settlement fraud. Viatical settlement fraud consists of but is not limited to the following committed by a person or the person's agents or employees:

(1) acts or omissions by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, engages in or permits the person's employees or agents to engage in acts that include but are not limited to:

(a) presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a viatical settlement provider, viatical settlement broker, premium finance lender, life insurer, life insurance producer, or any other person false material information; or

(b) concealing material information as part of, in support of, or concerning a fact material to one or more of the following:

(i) an application for the issuance of a viatical settlement contract or life insurance policy;

(ii) the underwriting of a viatical settlement contract or life insurance policy;

(iii) a claim for payment or benefit pursuant to a viatical settlement contract or life insurance policy;

(iv) premiums paid on a life insurance policy;

(v) payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or life insurance policy;

(vi) the reinstatement or conversion of a life insurance policy;

(vii) the solicitation, offer to enter into, or effectuation of a viatical settlement contract or life insurance policy;

(viii) the issuance of written evidence of viatical settlement contracts or life insurance; or

(ix) any application for, the existence of, or any payments related to a loan secured directly or indirectly by any interest in a life insurance policy.

(2) employing any device, scheme, or artifice to defraud in the business of viatical settlements;

(3) removing, concealing, altering, destroying, or sequestering from the commissioner the assets or records of a licensee or other person engaged in the business of viatical settlements;

(4) misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;

(5) transacting the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of viatical settlements;

(6) filing with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact;

(7) engaging in embezzlement, theft, misappropriation, or conversion of money, funds, premiums, credits, or other property of a viatical settlement provider, viatical settlement broker, insurer, insured, policy owner, or any other person engaged in the business of viatical settlements or life insurance;

(8) knowingly and with intent to defraud entering into, brokering, or otherwise dealing in a viatical settlement contract the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy if the policy owner or the owner's agent intended to defraud the issuer of the policy;

(9) attempting to commit or to assist, aid, or abet in the commission of or conspiring to commit the acts or omissions specified in this section; or

(10) misrepresenting the state of residence of a policy owner to be a state or jurisdiction that does not have a law substantially similar to Montana's Viatical Settlement Act, Title 33, chapter 20, part 13, or this part for the purpose of evading or avoiding the provisions of Montana law.

History: En. Sec. 3, Ch. 272, L. 2009.

Part 14
Property and Casualty Actuarial Opinion Act

33-1-1401. Short title. This part may be cited as the "Property and Casualty Actuarial Opinion Act".

History: En. Sec. 1, Ch. 50, L. 2009.

33-1-1402. Actuarial opinion of reserves and supporting documentation — definition. (1) Every property and casualty insurer doing business in this state, unless otherwise exempted by its domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled "Statement of Actuarial Opinion". The insurer shall file this opinion in accordance with the appropriate NAIC property and casualty annual statement instructions.

(2) (a) Every property and casualty resident domestic insurer that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary written by the insurer's appointed actuary. This actuarial opinion summary must be filed in accordance with the appropriate NAIC property and casualty annual statement instructions and is considered to be a document supporting the actuarial opinion required in subsection (1).

(b) A foreign or alien authorized insurer shall provide to the commissioner the actuarial opinion summary upon request.

(3) (a) An actuarial report and its underlying work papers as required by the appropriate NAIC property and casualty annual statement instructions must be prepared to support each actuarial opinion.

(b) If the insurer fails to provide a supporting actuarial report or work papers at the request of the commissioner or the commissioner determines that the supporting actuarial report or work papers provided by the insurer are otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and basis for the opinion and prepare a supporting actuarial report or work papers.

(4) The appointed actuary is not liable for damages to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion except in cases of fraud or willful misconduct on the part of the appointed actuary.

(5) For the purposes of this part, "actuarial report" means a document or presentation prepared as a formal means of conveying the actuary's professional conclusions and recommendations and communicating the methods and procedures used to reach the conclusions and recommendations, including any supporting documents.

History: **En. Sec. 2, Ch. 50, L. 2009.**

33-1-1403. Confidentiality. (1) The statement of actuarial opinion must be provided with the annual statement in accordance with the appropriate NAIC property and casualty annual statement instructions and is a public record within the meaning of 2-6-1002.

(2) (a) Actuarial reports, work papers, and actuarial opinion summaries retained by the commissioner are trade secrets and are privileged. The materials must be given confidential treatment, are not subject to subpoena, and are not subject to discovery, and the materials are not admissible in evidence in any private civil litigation.

(b) Subsection (2)(a) does not limit the commissioner's authority to release the documents to the actuarial board for counseling and discipline if the material is required for the board's professional disciplinary proceedings and if the board establishes procedures satisfactory to the commissioner to preserve the confidentiality of the documents.

(3) This section does not limit the commissioner's authority to use the actuarial reports, work papers, actuarial opinion summaries, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(4) The commissioner and any person who receives actuarial reports, work papers, actuarial opinion summaries, or other information while acting under the authority of the commissioner may not testify in any private civil action concerning the documents or information subject to the provisions of subsection (2).

(5) To assist in the performance of the commissioner's duties, the commissioner may provide and receive documents and information pursuant to 33-1-311.

(6) A waiver of privilege or claim of confidentiality in the actuarial reports, work papers, or actuarial opinion summaries does not result from disclosure to the commissioner under this section or result from the exchange of documents and information authorized in subsections (2)(b) and (5).

History: **En. Sec. 3, Ch. 50, L. 2009; amd. Sec. 52, Ch. 348, L. 2015.**

Part 15
Insurance Fraud Penalties

33-1-1501. No limitation on prosecutions. Nothing in this part limits the prosecution of any conduct defined as an offense in Title 45.

History: **En. Sec. 1, Ch. 396, L. 2017.**

33-1-1502. Application of criminal law and procedure. (1) Unless a rule or statute specifically states otherwise, the provisions of Titles 45 and 46 apply to the enforcement of the offenses provided for in this part.

(2) In any prosecution for the offenses provided for and charged under this part, for the purposes of and in addition to the provisions of 46-2-101 and 46-3-110, offenses are deemed to have been committed in any of the following locations:

(a) the county or judicial district in which the purported loss, damage, or accident occurs;

(b) the county or judicial district in which the insurance policy provides coverage or, in the case of motor vehicle insurance, where the vehicle is garaged; or

(c) the county or judicial district in which money or other insurance proceeds were received for the fraudulent act.

History: En. Sec. 2, Ch. 396, L. 2017; amd. Sec. 6, Ch. 157, L. 2023.

33-1-1503. Statute of limitations. (1) A prosecution for a felony stated in this part must be commenced within 5 years after it was committed.

(2) A prosecution for a misdemeanor stated in this part must be commenced within 3 years after it was committed.

(3) An offense is committed either when every element occurs or, when the offense is based upon a continuing course of conduct, at the time when the course of conduct is terminated. Time starts to run on the day after the offense is committed.

(4) A prosecution is commenced either when an indictment is found or an information or complaint is filed.

History: En. Sec. 3, Ch. 396, L. 2017.

33-1-1504. Criminal insurance fraud. (1) A person commits the offense of insurance fraud when the person purposely or knowingly:

(a) for the purpose of obtaining any money or benefit, presents or causes to be presented to any person any written or oral statement, including computer-generated documents, containing false, incomplete, or misleading information concerning any fact or thing material to, as part of, or in support of a claim for payment or other benefit pursuant to an insurance policy;

(b) presents or causes to be presented to or by an insurer, as defined in 33-1-201, or to an insurance producer or administrator, as defined in 33-17-102, a materially false or altered application of insurance;

(c) as a health care provider as defined in 33-38-102, submits a false or altered bill or report of physical condition to an insurer; or

(d) presents or causes to be presented false, incomplete, or misleading insurance documents to any person.

(2) (a) A person convicted of criminal insurance fraud involving a benefit or benefits with a value not exceeding $1,500 shall be fined not more than $1,500 or be imprisoned in the county detention center for not more than 6 months, or both.

(b) A person convicted of the offense of insurance fraud involving a benefit or benefits with a value exceeding $1,500 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of insurance fraud involving a common scheme as defined in 45-2-101 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

History: En. Sec. 4, Ch. 396, L. 2017.

33-1-1505. Theft of viatical settlement proceeds. (1) A person commits the offense of theft of viatical settlement proceeds when the person purposely or knowingly obtains or exerts unauthorized control over money, funds, premiums, credits, or other property of a viatical settlement provider, viatical settlement broker, insurer, insured, policy owner, or any other person engaged in the business of viatical settlements.

(2) For purposes of this section, "viatical settlement provider" and "viatical settlement broker" have the meanings provided in 33-20-1302.

(3) (a) A person convicted of theft of viatical settlement proceeds involving property with a value not exceeding $1,500 shall be fined not more than $1,500 or be imprisoned in the county detention center for not more than 6 months, or both.

(b) A person convicted of the offense of theft of viatical settlement proceeds involving property with a value exceeding $1,500 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of viatical settlement proceeds involving a common scheme as defined in 45-2-101 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

History: En. Sec. 5, Ch. 396, L. 2017.

33-1-1506. Theft of medical care discount card fee. (1) A person commits the offense of theft of medical care discount card fee when the person purposely or knowingly obtains or exerts unauthorized control over any amount of money paid by a user or consumer to a health care provider, a medical care discount card provider, or a medical care discount card supplier for a medical care discount card.

(2) For purposes of this section, "medical care discount card", "health care provider", and "medical care discount card provider" have the meanings provided in 33-38-102.

(3) (a) A person convicted of theft of medical care discount card fee involving a value not exceeding $1,500 shall be fined not more than $1,500 or be imprisoned in the county detention center for not more than 6 months, or both.

(b) A person convicted of the offense of theft of medical care discount card fee involving a value exceeding $1,500 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of medical care discount card fee involving a common scheme as defined in 45-2-101 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

History: En. Sec. 6, Ch. 396, L. 2017.

33-1-1507. Theft of pharmacy discount card fee. (1) A person commits the offense of theft of pharmacy discount card fee when the person purposely or knowingly obtains or exerts unauthorized control over any amount of money paid by a user or consumer to a prescription drug provider or a pharmacy discount card supplier for a pharmacy discount card.

(2) For purposes of this section, "pharmacy discount card", "pharmacy discount card supplier", and "prescription drug provider" have the meanings provided in 33-38-102.

(3) (a) A person convicted of theft of pharmacy discount card fee involving a value not exceeding $1,500 shall be fined not more than $1,500 or be imprisoned in the county detention center for not more than 6 months, or both.

(b) A person convicted of the offense of theft of pharmacy discount card fee involving a value exceeding $1,500 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of pharmacy discount card fee involving a common scheme as defined in 45-2-101 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

History: En. Sec. 7, Ch. 396, L. 2017.

33-1-1508. Theft of insurance premium. (1) A person commits the offense of theft of insurance premium when the person purposely or knowingly exerts unauthorized control over money paid as insurance premium:

(a) by failing to provide insurance premium received for a particular insurance policy to the insurer; or

(b) knowing that insurance coverage will not be provided.

(2) For purposes of this section "insurance premium" has the same meaning as "premium" provided in 33-15-102.

(3) (a) A person convicted of theft of insurance premium involving a value not exceeding $1,500 shall be fined not more than $1,500 or be imprisoned in the county detention center for not more than 6 months, or both.

(b) A person convicted of the offense of theft of insurance premium involving a value exceeding $1,500 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of insurance premium involving a common scheme as defined in 45-2-101 shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

History: En. Sec. 8, Ch. 396, L. 2017.

33-1-1509. License offenses. (1) A person commits the offense of conducting an insurance transaction without a license when the person purposely or knowingly solicits, negotiates, or sells insurance, as defined in 33-1-201, without first obtaining a license to conduct insurance transactions from the commissioner of insurance pursuant to Title 33.

(2) Except as provided in subsection (1), a person commits the offense of operating without a required license when the person purposely or knowingly engages in the acts of an insurance adjuster, insurance consultant, public adjuster, or temporary insurance producer, as those acts are set out in 33-17-102, 33-17-103, 33-17-216, and 33-17-1502, without first obtaining a license from the commissioner of insurance pursuant to Title 33.

(3) A corporation or other entity commits the offenses stated in this section when:

(a) a director, officer, servant, employee, or other person who is authorized to act on behalf of the entity commits the prohibited acts; or

(b) a manager or similarly empowered agent of the entity authorizes, requests, or commands the commission of the prohibited acts.

(4) A person convicted of a license offense shall be fined an amount not to exceed $50,000 or be imprisoned in the state prison for a term not to exceed 10 years, or both.

History: **En. Sec. 9, Ch. 396, L. 2017.**

33-1-1510. Surplus lines insurance offenses. (1) A person commits the offense of surplus lines offense if the person knowingly or negligently:

(a) issues or delivers a false policy or cover note or certification of insurance, as those documents are described in 33-2-308, related to the terms of a surplus lines insurance policy; or

(b) fails to notify an insured of a material change in the coverage described in 33-2-308 in writing within 30 days of any material change in the insurance coverage.

(2) A person convicted of a surplus lines insurance offense shall be fined not less than $50 or more than $1,000 or be imprisoned in the county detention center for not less than 30 days or more than 90 days, or both.

History: **En. Sec. 10, Ch. 396, L. 2017.**

33-1-1511. Failure or refusal to cooperate with commissioner. (1) A person commits the offense of failure or refusal to cooperate with the insurance commissioner when the person purposely or knowingly fails or refuses to cooperate with the commissioner during a dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer or an investigation of such matters described in Title 33, chapter 2, part 13.

(2) A corporation or other entity commits the offense of failure or refusal to cooperate with the insurance commissioner when:

(a) a director, officer, servant, employee, or other person who is authorized to act on behalf of the entity purposely or knowingly fails or refuses to cooperate with the commissioner during a dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer or an investigation of such matters described in Title 33, chapter 2, part 13; or

(b) a manager or similarly empowered agent of the entity purposely or knowingly authorizes, requests, or commands the failure or refusal to cooperate with the commissioner during a dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer or an investigation of such matters described in Title 33, chapter 2, part 13.

(3) For purposes of this section, cooperation includes but is not limited to:

(a) responding in writing within 60 days to any written inquiry from the commissioner requesting a response;

(b) making available to the commissioner any information in the insurer's possession, custody, or control, regardless of the form in which the information exists; or

(c) engaging in the necessary procedures related to dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of an insurer.

(4) A person or entity convicted of failure or refusal to cooperate with the insurance commissioner shall be fined an amount not to exceed $10,000 or be imprisoned in a county detention facility for a term not to exceed 1 year, or both.

History: **En. Sec. 11, Ch. 396, L. 2017.**

33-1-1512. Records and assets offenses. (1) A person commits the offense of unlawful removal or unlawful concealment of records or assets when, with the purpose to prevent the commissioner from fulfilling the duties set out in Title 33, the person purposely or knowingly removes from this state the records or assets required by 33-3-401 of a domestic insurer as defined in 33-1-201.

(2) A corporation or other entity commits the offense of unlawful removal or unlawful concealment of records or assets when, with the purpose to prevent the commissioner from fulfilling the duties set out in Title 33:

(a) a director, officer, servant, employee, or other person who is authorized to act on behalf of the entity purposely or knowingly removes from this state or conceals the records or assets required by 33-3-401 of a domestic insurer as defined in 33-1-201; or

(b) a manager or similarly empowered agent of the entity purposely or knowingly authorizes, requests, or commands the removal from this state or concealment of the records or assets required by 33-3-401 of a domestic insurer as defined in 33-1-201.

(3) A person or entity convicted of the unlawful removal or unlawful concealment of records or assets shall be fined an amount not to exceed $10,000 or be imprisoned in the state prison for a term not to exceed 5 years, or both.

History: **En. Sec. 12, Ch. 396, L. 2017.**

CHAPTER 2

REGULATION OF INSURANCE COMPANIES

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Part 1
Authorization of Insurers

33-2-101. Certificate of authority required. (1) Except as expressly otherwise provided in this code, a person acting as an insurer and an insurer transacting insurance in this state must have a subsisting certificate of authority issued by the commissioner.

(2) An insurer that has or maintains in Montana any office, representative, or facility for the solicitation or servicing of any kind of insurance in any other state must be authorized to transact the same kind of insurance in this state.

History: En. Sec. 46, Ch. 286, L. 1959; R.C.M. 1947, 40-2801; amd. Sec. 1, Ch. 562, L. 2005; amd. Sec. 18, Ch. 396, L. 2017.

Cross-References

Examination prior to initial issuance of certificate, 33-1-401.

Lack of or revocation of certificate — grounds for conservation or liquidation of assets — alien or foreign insurer, 33-2-1379.

Membership in Montana Insurance Guaranty Association — condition of authority to operate in state, 33-10-103, 33-10-203.

Motor club service companies — licensing, 61-12-302.

33-2-102. Exceptions to certificate of authority requirement. A certificate of authority shall not be required of an insurer, not otherwise authorized in this state, as to the following transactions:

(1) transactions relative to its policies lawfully written in Montana or liquidation of assets and liabilities of the insurer (other than collection of new premiums), all as resulting from its former authorized operations in Montana;

(2) transactions relative thereto subsequent to issuance of a policy covering only subjects of insurance not resident, located, or expressly to be performed in Montana at time of issuance, and which coverage was lawfully solicited, written, and delivered outside Montana;

(3) transactions pursuant to surplus lines coverages lawfully written pursuant to part 3 of this chapter;

(4) reinsurance, except as to domestic reinsurers.

History: En. Sec. 47, Ch. 286, L. 1959; R.C.M. 1947, 40-2802.

33-2-103. Admission for investment only. A foreign insurer may transact business in this state without certificate of authority for the purpose and to the extent only of investing its funds in Montana real estate or in securities secured thereby by complying with the applicable laws of this state other than this code. Such an insurer shall not be subject to any other provision of this code.

History: En. Sec. 48, Ch. 286, L. 1959; R.C.M. 1947, 40-2803.

Cross-References

Securities regulation, Title 30, ch. 10.

33-2-104. Representing or aiding unauthorized insurer prohibited. (1) A person may not directly or indirectly act as insurance producer in this state for, or otherwise represent or aid on behalf of another, any insurer not authorized to transact insurance in this state in the solicitation, negotiation, or effectuation of insurance or of annuity contracts, inspection of risks, fixing of rates, investigation or adjustment of losses, collection of premiums, or any other transaction of insurance with respect to subjects of insurance resident, located or to be performed in this state.

(2) This section does not apply to:

(a) acceptance of service of process by the commissioner under 33-1-613; or

(b) surplus lines insurance and other transactions for which a certificate of authority is not required of an insurer as stated in 33-2-102.

History: En. Sec. 176, Ch. 286, L. 1959; R.C.M. 1947, 40-3401; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 2, Ch. 562, L. 2005; amd. Sec. 19, Ch. 396, L. 2017; amd. Sec. 4, Ch. 62, L. 2019.

Cross-References

Felony, 46-18-213.

33-2-105. Suits by unauthorized insurers prohibited. Except as to transactions permitted under 33-2-102, no unauthorized insurer shall institute or file or cause to be instituted or filed any suit, action, or proceeding in this state to enforce any right, claim, or demand arising out of any insurance transaction in this state until such insurer has obtained a certificate of authority to transact such insurance in this state.

History: En. Sec. 177, Ch. 286, L. 1959; R.C.M. 1947, 40-3402; amd. Sec. 8, Ch. 198, L. 1979.

Cross-References

Unauthorized Insurers Process Act, 33-1-611 through 33-1-616.

33-2-106. General eligibility of insurers. (1) To qualify for and hold authority to transact insurance in this state, an insurer must be otherwise in compliance with this code and with its charter powers and must be an incorporated stock insurer, an incorporated mutual insurer, or a reciprocal insurer, all of the same general type as may hereafter be formed as a domestic insurer under this code.

(2) No foreign insurer shall be authorized to transact insurance in Montana which does not maintain reserves as required by part 5 of this chapter applicable to the kind or kinds of insurance transacted by such insurer, wherever transacted in the United States, or which transacts business anywhere in the United States on the assessment plan, stipulated premium plan, or any similar plan.

(3) No foreign insurer which is directly or indirectly owned or controlled in whole or in substantial part by any government or governmental agency shall be authorized to transact insurance in Montana unless it was so owned and first so authorized prior to January 1, 1957. Membership or subscribership in a mutual or reciprocal insurer by virtue of being a policyholder thereof, ownership of stock or other security which does not have voting rights with respect to the management of the insurer, or supervision of an insurer by public authority shall not be deemed to be an ownership or control of the insurer for the purposes of this provision.

History: En. Sec. 49, Ch. 286, L. 1959; R.C.M. 1947, 40-2804.

Cross-References

Examination prior to issuance of initial certificate, 33-1-401.

33-2-107. Name — dissimilar. (1) No insurer shall be authorized to transact insurance in this state which has or uses a name so similar to that of another insurer already so authorized as likely to mislead the public.

(2) No life insurer shall be authorized which has or uses a name deceptively similar to that of another insurer authorized to transact insurance in this state within the preceding 10 years if life insurance policies originally issued by such other insurer are still outstanding in this state.

(3) No insurer shall be so authorized which has or uses a name which tends to deceive or mislead as to the type of organization of the insurer.

(4) In case of conflict of names between two insurers or a conflict otherwise prohibited under the foregoing subsections of this section, the commissioner may permit or require the more recently authorized insurer to use in Montana such supplementation or modification of its name or such business name as may reasonably be necessary to avoid such conflict.

History: En. Sec. 50, Ch. 286, L. 1959; R.C.M. 1947, 40-2805.

Cross-References

Assumed business names, Title 30, ch. 13, part 2.

33-2-108. Combinations of insuring powers. (1) Except as provided in subsections (2), (3), and (4) and 33-25-213, an insurer which otherwise qualifies therefor may be authorized to transact any one kind or combination of kinds of insurance as defined in 33-1-205 through 33-1-212.

(2) A life insurer may also grant annuities but shall not be authorized to transact any other kind of insurance other than disability, except that if the insurer is otherwise qualified therefor, the commissioner shall continue to so authorize any life insurer which, immediately prior to January 1, 1961, was lawfully authorized to transact in this state a kind or kinds of insurance in addition to life and disability.

(3) A reciprocal insurer shall not transact life insurance.

(4) A title insurer shall be a stock insurer.

History: En. Sec. 51, Ch. 286, L. 1959; R.C.M. 1947, 40-2806; amd. Sec. 16, Ch. 519, L. 1985.

Cross-References

Reciprocal insurers, Title 33, ch. 5.

33-2-109. Capital or surplus funds required. (1) To qualify for authority to transact any one kind of insurance, as defined in 33-1-205 through 33-1-212, or combinations of kinds of insurance as shown below, an insurer shall possess and maintain unimpaired paid-in capital stock, if a stock insurer, or surplus, if a mutual or foreign reciprocal insurer, in an amount not less than is applicable under the schedules below and shall possess when first authorized to transact insurance any additional funds as surplus as required under 33-2-110:

(a) Kind or kinds of insurance	Minimum capital or surplus required
Life	$200,000
Disability	200,000
Life and disability	300,000
Credit life and disability	50,000
Property	400,000
Marine	400,000
Casualty	
All lines, except workers' compensation	400,000
All lines, including workers' compensation	600,000
Surety	500,000
Title	200,000
Multiple lines, two or more of property, marine, casualty, or surety	800,000

(b) For insurers licensed on or after October 1, 1999:

Kind or kinds of insurance	Minimum capital or surplus required
Life	$600,000
Disability	500,000
Life and disability	750,000
Credit life and disability	150,000
Property	500,000
Marine	500,000
Casualty	
All lines, except workers' compensation	500,000
All lines, including workers' compensation	750,000
Surety	500,000
Title	500,000
Multiple lines, two or more of property, marine, casualty, or surety	1,000,000

(2) Surplus requirements for qualification to transact one or more kinds of insurance for domestic mutual insurers are governed by Title 33, chapter 3, and surplus requirements for domestic reciprocal insurers are governed by Title 33, chapter 5.

(3) Capital and surplus requirements must be based upon all the kinds of insurance actually transacted or to be transacted by the insurer in any areas in which it operates, whether or not only a portion of the kinds are to be transacted in this state.

(4) A life insurer may also grant annuities without additional capital or additional surplus.

(5) For a credit life and disability insurer that is not a resident domestic insurer as defined in 33-1-201 and 33-1-202, the capital or surplus required by this section is an amount equal to four times the minimum capital or surplus required for credit life and disability pursuant to subsection (1).

History: En. Sec. 52, Ch. 286, L. 1959; amd. Sec. 1, Ch. 319, L. 1977; R.C.M. 1947, 40-2807(part); amd. Sec. 2, Ch. 303, L. 1981; amd. Sec. 3, Ch. 202, L. 1983; amd. Sec. 12, Ch. 472, L. 1999.

33-2-110. Special surplus required. In addition to the minimum paid-in capital stock (stock insurers) or minimum surplus (mutual and reciprocal insurers) required by 33-2-109, special surplus shall be possessed by insurers as follows:

(1) All stock insurers and mutual and foreign reciprocal insurers which have actively transacted insurance in their state of domicile as an authorized insurer for less than 5 years or, if an alien insurer, have transacted insurance as an authorized insurer in at least one state of the United States for less than 5 years when first authorized to transact insurance in this state shall have a surplus or additional surplus equal to not less than 100% of the paid-in capital stock (if a stock insurer) or surplus (if a mutual or foreign reciprocal) otherwise required under 33-2-109 for the kinds of insurance to be transacted.

(2) Insurers that have actively transacted insurance as authorized insurers in one or more states of the United States for more than 5 years shall possess, when first authorized in this state, surplus or additional surplus equal to not less than 50% of the paid-in capital stock (if a stock insurer) or surplus (if a mutual or foreign reciprocal insurer) otherwise required under 33-2-109.

(3) Insurers authorized to transact multiple lines of insurance in this state shall at all times have and maintain surplus of not less than $100,000, in addition to the capital (if a stock insurer) or surplus (if a mutual or foreign reciprocal insurer) required by 33-2-109. The amount of such surplus shall be included within the surplus required of newly authorized insurers pursuant to subsections (1) and (2) of this section.

History: En. Sec. 53, Ch. 286, L. 1959; R.C.M. 1947, 40-2808; amd. Sec. 3, Ch. 303, L. 1981.

33-2-111. Deposit requirement. (1) An insurer may not be authorized to transact insurance in this state unless it makes and maintains in trust in this state through the commissioner for the protection of all its policyholders or of all its policyholders and creditors a deposit of cash or securities eligible for deposit under 33-2-603 in an amount not less than the minimum paid-in capital stock, if a stock insurer, or minimum surplus, if a mutual or reciprocal insurer, other than special surplus, required to be maintained for authority to transact the kinds of insurance to be transacted, except as to:

(a) title insurers, the deposit must be in the amount of $100,000;

(b) foreign insurers, in lieu of the deposit or part of the deposit in this state, the commissioner shall accept the certificate in proper form of the public official having supervision over insurers in any other state to the effect that a like deposit or part of a deposit by the insurer is being maintained in public custody in that state in trust for the purpose, among other reasonable purposes of protection of policyholders or creditors, or both, of the protection of all its policyholders or creditors, or both, in Montana;

(c) alien insurers, in lieu of the deposit or part of the deposit in this state, the commissioner shall accept evidence satisfactory to the commissioner that the insurer maintains within the United States by way of trust deposits with public depositaries or in trust institutions approved by the commissioner assets available for discharge of its United States insurance obligations. The assets must be in an amount not less than the outstanding liabilities of the insurer arising out of its insurance transactions in the United States, together with the larger of the following sums:

(i) the largest deposit required by this code to be made by foreign insurers transacting like kinds of insurance; or

(ii) $300,000.

(2) Deposits of foreign or alien insurers in another state must be in cash or securities, or both, of substantially the same quality as those eligible for deposit in this state under 33-2-603.

(3) Deposits of reserves by domestic life insurers must be made as provided in 33-2-416.

(4) Deposits made in this state are subject to the provisions of part 6 of this chapter.

History: **En. Sec. 54, Ch. 286, L. 1959; R.C.M. 1947, 40-2809; amd. Sec. 1, Ch. 238, L. 1979; amd. Sec. 1070, Ch. 56, L. 2009.**

33-2-112. Management qualifications and affiliations. The commissioner may not grant or continue authority to transact insurance in this state as to any insurer the principal management personnel of which is found by the commissioner to be untrustworthy or not of good character or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public or to its stockholders or that the commissioner has good reason to believe is affiliated directly or indirectly through ownership, control, management, reinsurance transactions, or other insurance or business relations with any person or persons whose business operations, to the detriment of insurers, stockholders, or creditors, are or have been marked by manipulation of assets, accounts, or reinsurance or by bad faith.

History: **En. Sec. 55, Ch. 286, L. 1959; R.C.M. 1947, 40-2810; amd. Sec. 1071, Ch. 56, L. 2009.**

33-2-113 and 33-2-114 reserved.

33-2-115. Application for certificate of authority. To apply for an original certificate of authority, an insurer shall file with the commissioner its application accompanied by the applicable fees as specified in 33-2-708, showing its name, location of its home office or principal office in the United States, if an alien insurer, kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile, and any additional information that the commissioner may reasonably require. The application must be accompanied by the following documents, as applicable:

(1) if a foreign insurer, a copy of its corporate charter or articles of incorporation, with all amendments, certified by the public officer with whom the originals are on file in the state or country of domicile;

(2) if a mutual insurer, a copy of its bylaws as amended, certified by its secretary or other officer having custody of the bylaws;

(3) if a reciprocal insurer, copies of the power of attorney of its attorney-in-fact and of its subscribers' agreement, if any, certified by its attorney-in-fact;

(4) a copy of its financial statement as of the preceding December 31, sworn to by at least two executive officers of the insurer or certified by the public insurance supervisory official of the insurer's state of domicile or of entry into the United States;

(5) a copy of report of last examination, if any, made of the insurer, certified by the insurance supervisory official of its state of domicile or of entry into the United States;

(6) if a foreign or alien insurer, appointment of a registered agent to receive service of legal process pursuant to 33-1-605;

(7) if a foreign or alien insurer, a certificate of the public official having supervision of insurance in its state or country of domicile or state of entry into the United States, showing that it is authorized to transact the kinds of insurance proposed to be transacted in this state;

(8) if an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records;

(9) if a foreign insurer, certificate as to deposit if to be tendered pursuant to 33-2-111;

(10) if a domestic insurer, specimen copies of policies proposed to be offered in this state, together with premiums or premium rates applicable, or a declaration that the rates as applicable will be those promulgated by designated rating organizations authorized to file the rates in this state on behalf of the insurer.

History: **En. Sec. 56, Ch. 286, L. 1959; R.C.M. 1947, 40-2811; amd. Sec. 9, Ch. 380, L. 2003; amd. Sec. 5, Ch. 60, L. 2019.**

33-2-116. Issuance or refusal of certificate of authority — state ownership of certificate. (1) If upon completion of an insurer's application for a certificate of authority the commissioner finds that the insurer has met the requirements for a certificate of authority under this code, the commissioner shall issue to the insurer a proper certificate of authority.

If the commissioner does not find that the insurer is entitled to a certificate of authority, the commissioner shall issue an order refusing to issue a certificate. The commissioner shall act upon an application for a certificate of authority within 180 days after its completion.

(2) The certificate, if issued, must specify the kind or kinds of insurance the insurer is authorized to transact in Montana. At the insurer's request, the commissioner may issue a certificate of authority limited to particular types of insurance or insurance coverages within the scope of a kind of insurance as defined in 33-1-205 through 33-1-212.

(3) Although issued to the insurer, the certificate of authority is at all times the property of the state of Montana. Upon any expiration or termination of the certificate of authority, the insurer shall promptly destroy the certificate.

History: En. Sec. 57, Ch. 286, L. 1959; R.C.M. 1947, 40-2812; amd. Sec. 4, Ch. 303, L. 1981; amd. Sec. 1072, Ch. 56, L. 2009; amd. Sec. 2, Ch. 271, L. 2009; amd. Sec. 7, Ch. 157, L. 2023.

33-2-117. Renewal, expiration, reinstatement, and amendment of certificate of authority. (1) A certificate of authority issued or renewed under this code must continue in force as long as the insurer is entitled under this code and until suspended, revoked, or otherwise terminated. A certificate is subject to renewal by the insurer each year by payment on or prior to March 1 of the fee provided for in 33-2-708.

(2) If not continued by the insurer, the certificate of authority expires at midnight on May 31 following failure of the insurer to continue it in force. The commissioner shall promptly notify the insurer of its failure to pay the fee that can result in the expiration of its certificate of authority.

(3) The commissioner may reinstate a certificate of authority that the insurer has inadvertently permitted to expire after the insurer cures any failures resulting in expiration and upon payment of a fee of $100 for reinstatement. Otherwise, the insurer may be granted another certificate of authority only after filing an application and meeting all other requirements for an original certificate of authority in this state.

(4) The commissioner may amend a certificate of authority at any time to accord with changes in the insurer's charter of insuring powers.

History: En. Sec. 58, Ch. 286, L. 1959; R.C.M. 1947, 40-2813; amd. Sec. 1, Ch. 139, L. 1987; amd. Sec. 7, Ch. 379, L. 1995; amd. Sec. 1, Ch. 316, L. 1999; amd. Sec. 7, Ch. 63, L. 2015.

Cross-References

Failure to report — revoke or refuse to reinstate certificate, 33-2-701.

33-2-118. Mandatory revocation or suspension of certificate of authority. (1) The commissioner shall suspend or revoke an insurer's certificate of authority if:

(a) such action is required by any provision of this code;

(b) the insurer no longer meets the requirements for the authority originally granted, on account of deficiency of assets or otherwise; or

(c) the insurer's authority to transact insurance is suspended or revoked by its state of domicile, or state of entry into the United States if an alien insurer.

(2) Except in cases of insolvency or impairment of required capital or surplus or suspension or revocation by another state as referred to in subsection (1)(c) above, the commissioner shall give the insurer at least 15 days' notice in advance of any such suspension or revocation under this section.

History: En. Sec. 59, Ch. 286, L. 1959; R.C.M. 1947, 40-2814.

Cross-References

Revocation — alien or foreign insurer — grounds for conservation or liquidation of assets, 33-2-1379.

33-2-119. Suspension or revocation for violations and special grounds. (1) The commissioner may suspend or revoke an insurer's certificate of authority if, after a hearing, the commissioner finds that the insurer has:

(a) violated any lawful order of the commissioner or any provision of this code other than those for which suspension or revocation is mandatory;

(b) reinsured more than 90% of its risks resident, located, or to be performed in Montana, in another insurer. In considering suspension or revocation, the commissioner shall consider all relevant factors, including whether:

(i) after the reinsurance transaction all parties will be in compliance with Montana law; and

(ii) the transaction will substantially reduce protection and service to Montana policyholders.

(2) The commissioner shall, after a hearing, suspend or revoke an insurer's certificate of authority if the commissioner finds that the insurer:

(a) is in unsound condition or in a condition or using methods or practices in the conduct of its business that render its further transaction of insurance in Montana injurious or hazardous to its policyholders or to the public;

(b) has refused to be examined or to produce its accounts, records, and files for examination or if any of its officers have refused to give information with respect to its affairs, when required by the commissioner;

(c) has failed to pay any final judgment rendered against it in Montana within 30 days after the judgment became final;

(d) with such frequency as to indicate its general business practice in Montana, has without just cause refused to pay a proper claim arising under its policies, whether the claim is in favor of an insured or is in favor of a third person with respect to the liability of an insured to the third person, or without just cause compels the insured or claimant to accept less than the amount due the claimant or to employ attorneys or to bring suit against the insurer or insured to secure full payment or settlement of the claims;

(e) is affiliated with and under the same general management or interlocking directorate or ownership as another insurer that transacts direct insurance in Montana without having a certificate of authority, except as permitted as to a surplus lines insurer under part 3 of this chapter.

(3) The commissioner may, without advance notice or a hearing, immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings have been commenced in any state.

History: En. Sec. 60, Ch. 286, L. 1959; R.C.M. 1947, 40-2815; amd. Sec. 5, Ch. 303, L. 1981; amd. Sec. 2, Ch. 518, L. 1983; amd. Sec. 25, Ch. 537, L. 1987; amd. Sec. 46, Ch. 613, L. 1989; amd. Sec. 1, Ch. 620, L. 1989; amd. Sec. 2, Ch. 310, L. 1997.

Cross-References

Hearings by Commissioner, Title 33, ch. 1, part 7.
Grounds for rehabilitation of insurer, 33-2-1331.
Revocation — alien or foreign insurer — grounds for conservation or liquidation of assets, 33-2-1379.

33-2-120. Notice of suspension or revocation — effect upon producer's authority. (1) Upon suspending or revoking an insurer's certificate of authority, the commissioner shall give notice to the insurer and to its insurance producers in this state of record in the commissioner's office.

(2) The suspension or revocation must automatically suspend or revoke, as the case may be, the authority of all insurance producers to act as insurance producers of the insurer in this state, and the commissioner shall state that requirement in the notice to insurance producers provided for in subsection (1).

(3) The commissioner may also publish notice of revocation in one or more newspapers of general circulation published in this state.

History: En. Sec. 61, Ch. 286, L. 1959; R.C.M. 1947, 40-2816; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1073, Ch. 56, L. 2009.

33-2-121. Duration of suspension — insurer's obligations — reinstatement. (1) Suspension of an insurer's certificate of authority must be for a period fixed by the commissioner in the order of suspension and must continue until rescinded or otherwise removed by the commissioner. During the suspension, the commissioner may shorten the period by further order.

(2) During the period of the suspension the insurer shall file its annual statement and pay fees, licenses, and taxes as required under this code as if the certificate had continued in full force.

(3) If within the period of suspension the certificate of authority has not been terminated, the insurer's certificate of authority may be reinstated if the commissioner finds that the causes of the suspension have been removed or that the insurer is otherwise in compliance with the requirements of this code.

(4) Upon reinstatement of the insurer's certificate of authority, the authority of its insurance producers in this state to represent the insurer is reinstated.

(5) The commissioner shall forthwith notify both the insurer and its insurance producers in this state, as shown by the commissioner's records, of the reinstatement.

History: **En. Sec. 62, Ch. 286, L. 1959; R.C.M. 1947, 40-2817; amd. Sec. 1, Ch. 534, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1074, Ch. 56, L. 2009.**

33-2-122. Rights and duties of foreign insurer. Except as otherwise provided in this chapter, a foreign insurer which has a certificate of authority under this chapter shall, until its certificate is revoked or withdrawn, enjoy the same but no greater rights and privileges as a domestic insurer and shall be subject to the same duties, restrictions, penalties, and liabilities imposed upon a domestic insurer of like character.

History: **En. Sec. 1, Ch. 345, L. 1987.**

33-2-123 through 33-2-125 reserved.

33-2-126. Admission as domestic insurer — conversion to foreign insurer. (1) An insurer organized under the laws of any other state and admitted to do business in this state for the purposes of writing insurance may become a domestic insurer by complying with all of the laws relative to the organization and licensing of a domestic insurer of the same type, and designating its principal place of business in this state. An insurer complying with this subsection is entitled to a certificate of redomestication and a certificate of authority to transact business in this state, is subject to the authority and jurisdiction of this state, and has the same rights and obligations as other domestic insurers.

(2) A domestic insurer may, upon approval of the commissioner, transfer its domicile to any other state in which it is admitted to transact insurance. If the insurer is otherwise qualified, the commissioner shall approve a proposed transfer unless the commissioner determines a transfer is not in the interest of the policyholders of this state. Upon a transfer, the insurer ceases to be a domestic insurer.

History: **En. Sec. 1, Ch. 132, L. 1991; amd. Sec. 2, Ch. 316, L. 1999.**

33-2-127. Effects of transfer of domicile. The certificate of authority, producers' appointments and licenses, policy forms, rates, and other items that the commissioner allows that are in existence at the time an insurer admitted to transact insurance in this state transfers its corporate domicile to this or any other state continue in effect upon transfer if the insurer remains qualified to transact insurance in this state. All rates and outstanding policies of a transferring insurer remain in effect, and policies need not be endorsed as to the new name of the company or its domicile unless required by the commissioner. A transferring insurer either shall file new policy forms for use in this state with the commissioner on or before the effective date of the transfer or may use existing policy forms with the appropriate endorsements as allowed by the commissioner. A transferring insurer shall notify the commissioner of the proposed transfer and shall promptly file any resulting amendments to corporate documents required to be filed with the commissioner.

History: **En. Sec. 2, Ch. 132, L. 1991; amd. Sec. 1075, Ch. 56, L. 2009.**

33-2-128. Authority to promulgate rules and regulations. The commissioner may promulgate rules and regulations to carry out the purposes of 33-2-126 and 33-2-127.

History: **En. Sec. 3, Ch. 132, L. 1991.**

Cross-References

Adoption & publication of rules, Title 2, ch. 4, part 3.

Part 2
State of Entry — Trusteed Assets of Alien Insurers

Part Cross-References

Annual report — alien insurers — additional requirements, 33-2-701.

33-2-201. Scope of part. This part applies to all alien insurers using Montana as a state of entry to transact insurance in the United States.

History: **En. Sec. 599, Ch. 286, L. 1959; R.C.M. 1947, 40-5201.**

33-2-202. Required deposit of assets. (1) An alien insurer may use Montana as a state of entry to transact insurance in the United States by making and maintaining in this state a deposit of assets in trust with a solvent bank or trust company approved by the commissioner.

(2) The deposit, together with other trust deposits of the insurer held in the United States for the same purpose, must be in amount not less than the deposits required of an alien insurer under 33-2-111(1) and must consist of cash and securities of the same character and diversification as those eligible for the investment of the funds of domestic insurers under chapter 12.

(3) A deposit under this section may be referred to as "trusteed assets".

History: **En. Sec. 600, Ch. 286, L. 1959; R.C.M. 1947, 40-5202; amd. Sec. 37, Ch. 304, L. 1999.**

33-2-203. Existing trusts. All trusts of trusteed assets created before January 1, 1961, and existing on that date shall be continued under the instruments creating them unless inconsistent with the provisions of this part.

History: **En. Sec. 601, Ch. 286, L. 1959; R.C.M. 1947, 40-5203.**

33-2-204. Purpose and duration. The deposit required by 33-2-202 shall be for the benefit, security, and protection of the policyholders or policyholders and creditors of the insurer in the United States. It shall be maintained as long as there is outstanding any liability of the insurer arising out of its insurance transactions in the United States.

History: **En. Sec. 602, Ch. 286, L. 1959; R.C.M. 1947, 40-5204.**

Cross-References

Purposes of deposits, 33-2-602.

33-2-205. Trust agreement — approval. (1) The deposit referred to in 33-2-202 must be made under a written trust agreement between the insurer and the trustee, consistent with the provisions of this part, and must be authenticated in the form and manner that the commissioner may designate or approve.

(2) The agreement may not be effective until filed with and approved in writing by the commissioner. The commissioner may not approve any trust agreement found by the commissioner not to be in compliance with law or the terms of which do not in fact provide reasonably adequate protection for the insurer's policyholders or creditors, or both, in the United States.

History: **En. Sec. 603, Ch. 286, L. 1959; R.C.M. 1947, 40-5205; amd. Sec. 1076, Ch. 56, L. 2009.**

Cross-References

Trust Code, Title 72, ch. 38.

33-2-206. Authority to execute trust agreement. An alien insurer using or proposing to use Montana as a state of entry to transact insurance in the United States, whether or not it is then authorized to transact insurance in this state, is authorized to make and execute any trust agreement required by this part.

History: **En. Sec. 604, Ch. 286, L. 1959; R.C.M. 1947, 40-5206.**

33-2-207. Amendment of trust agreement. A trust agreement may be amended, but the amendment shall not be effective until filed with and approved in writing by the commissioner as being in compliance with this part.

History: **En. Sec. 605, Ch. 286, L. 1959; R.C.M. 1947, 40-5207.**

33-2-208. Withdrawal of approval. The commissioner's approval of any trust agreement or of any amendment of a trust agreement may be withdrawn by the commissioner if the commissioner finds upon hearing, after notice to the insurer and the trustee or trustees, that the requisites for approval, as provided in this part, no longer exist.

History: **En. Sec. 606, Ch. 286, L. 1959; R.C.M. 1947, 40-5208; amd. Sec. 1077, Ch. 56, L. 2009.**

Cross-References

Hearing and notice requirements, Title 33, ch. 1, part 7.

33-2-209. Title to trusteed assets. Title to the trusteed assets is vested in the trustee or trustees and their successors for the purposes of the trust deposit, and the trust agreement shall so provide.

History: **En. Sec. 607, Ch. 286, L. 1959; R.C.M. 1947, 40-5209.**

33-2-210. Assets kept separate. The trustee shall keep the trusteed assets separate from other assets and shall maintain a record thereof sufficient to identify trusteed assets at all times.

History: En. Sec. 608, Ch. 286, L. 1959; R.C.M. 1947, 40-5210.

33-2-211. Statement of trustee. (1) The trustee of trusteed assets shall, from time to time, file with the commissioner statements, in the form that the commissioner may designate and request in writing, certifying the character of the assets and the amounts of the assets.

(2) If the trustee fails to file any statement described in subsection (1) after a request for the statement and expiration of a reasonable time, the commissioner may suspend or revoke the certificate of authority of the insurer.

History: En. Sec. 609, Ch. 286, L. 1959; R.C.M. 1947, 40-5211; amd. Sec. 1078, Ch. 56, L. 2009.

Cross-References

Trust administration, Title 72, ch. 38.

33-2-212. Examination of assets. The commissioner may examine trusteed assets of any insurer at any time in accordance with the same conditions and procedures as govern the examination of insurers in general under chapter 1 of this title.

History: En. Sec. 610, Ch. 286, L. 1959; R.C.M. 1947, 40-5212.

Cross-References

Revocation of certificate of authority, 33-2-118, 33-2-119.

33-2-213. Withdrawal of assets. (1) A trust agreement under this part must provide, in substance, that withdrawals of trusteed assets may not be made by the insurer or permitted by the trustee without the written authorization or approval of the commissioner in advance of the withdrawal, except as follows:

(a) any or all income, earnings, dividends, or interest accumulations of the trusteed assets may be paid over to the United States manager of the insurer upon request of the insurer or the manager;

(b) for substitution, coincidentally with a withdrawal, of other securities or assets of value at least equal in amount to those being withdrawn if the substituted securities or assets are eligible for investment of the funds of domestic insurers under chapter 12, if the withdrawal is requested in writing by the insurer's United States manager pursuant to general or specific written authority previously given or delegated by the insurer's board of directors or other similar governing body and a copy of the authority has been filed with the trustee;

(c) for the purpose of making deposits required by law in any state in which the insurer is or becomes an authorized insurer, for the protection of the insurer's policyholders or policyholders and creditors in such state or in the United States, if a withdrawal does not reduce the insurer's deposit in this state to an amount less than the minimum deposit required under 33-2-111(1)(c)(i) and (1)(c)(ii). The trustee shall transfer any assets withdrawn and in the amount required to be deposited in the other state direct to the depositary required to receive the deposit in the other state, as certified in writing by the public official having supervision of insurance in the other state.

(d) for the purpose of transferring the trusteed assets to an official liquidator, conservator, or rehabilitator pursuant to the order of a court of competent jurisdiction.

(2) The commissioner shall authorize or approve withdrawal of only the assets that are in excess of the amount of assets required to be held in trust under 33-2-202 or as may otherwise be consistent with the provisions of this part.

(3) If at any time the insurer becomes insolvent or if its assets held in the United States are less in amount than as required under 33-2-111(1)(c), the commissioner shall in writing order the trustee to suspend the right of the insurer or any other person to withdraw assets as authorized under subsections (1)(a), (1)(b), and (1)(c), and the trustee shall comply with the order and until the further order of the commissioner.

History: En. Sec. 611, Ch. 286, L. 1959; R.C.M. 1947, 40-5213; amd. Sec. 38, Ch. 304, L. 1999.

Cross-References

Trust administration, Title 72, ch. 38.

33-2-214. Substitution of trustee. (1) A new trustee or new trustees may be substituted for the original trustee or trustees of trusteed assets in the event of a vacancy or for other proper cause. Any substitution is subject to the commissioner's approval.

(2) If the trustees of any trusteed assets are individuals and if the number of trustees is reduced to less than three by death, resignation, or otherwise, the commissioner shall require that there be substituted for the trustees a bank or trust company in this state approved by the commissioner.

History: **En. Sec. 612, Ch. 286, L. 1959; R.C.M. 1947, 40-5214; amd. Sec. 1079, Ch. 56, L. 2009.**

33-2-215. Canadian insurers. The provisions of this part applicable to a United States manager shall, in the case of insurers domiciled in Canada, be deemed to refer to the president, vice-president, secretary, or treasurer of such a Canadian insurer.

History: **En. Sec. 613, Ch. 286, L. 1959; R.C.M. 1947, 40-5215.**

Part 3

Authorization of Surplus Lines Insurers, Insurance Producers, and Insurance

33-2-301. Short title — purpose — definitions. (1) This part constitutes and may be referred to as "The Surplus Lines Insurance Law".

(2) The purpose of this part is to:

(a) protect persons seeking insurance in this state;

(b) permit surplus lines insurance to be placed with reputable and financially sound unauthorized insurers and, except with a domestic surplus lines insurer, to be exported from this state pursuant to this part;

(c) establish a system of regulation that will permit orderly access to surplus lines insurance in this state and encourage unauthorized insurers to provide new and innovative types of insurance to consumers in this state; and

(d) protect revenues of this state.

(3) As used in this part, the following definitions apply:

(a) "Affiliated" means that a person directly or indirectly controls, is controlled by, or is under common control with the insured.

(b) "Affiliated group" means any group of persons that are affiliated.

(c) "Approved risk list" means the list approved by the commissioner of the kinds of insurance presumed unobtainable from authorized insurers when Montana is the home state of the insured.

(d) "Authorized insurer" means an insurer authorized pursuant to 33-2-101 to transact insurance in this state.

(e) (i) "Business entity" means a corporation, a limited liability company, an association, a partnership, a limited liability partnership, or other legal entity.

(ii) The term does not include an individual.

(f) "Control", including the terms "controlled by" and "under common control with", means that:

(i) the person directly or indirectly or acting through one or more other persons owns, controls, or has the power to vote 25% or more of any class of voting securities of a business entity; or

(ii) the person controls in any manner the election of a majority of the directors or trustees of a business entity.

(g) (i) "Disability income insurance" has the meaning provided in 33-1-235 for:

(A) individuals employed in professional sports or the entertainment industry; or

(B) a business entity insuring a principal to cover liability or provide assurance for the business entity's loans or contracts.

(ii) Disability income insurance sold on the surplus lines market must be unavailable from or limited by an authorized insurer.

(h) "Eligible surplus lines insurer" means an unauthorized insurer that is eligible to issue surplus lines insurance under 33-2-307.

(i) "Exempt commercial purchaser" has the meaning provided in 33-2-318.

(j) "Export" means to place surplus lines insurance with an unauthorized insurer.

(k) "Home state" means, with respect to an insured:

(i) the state in which the insured maintains its principal place of business or, in the case of an individual, the individual's principal residence;

(ii) if 100% of the insured risk is located outside the state referred to in subsection (3)(k)(i), the state with the greatest allocated percentage of the insured's taxable premium for that surplus lines insurance contract;

(iii) if more than one insured from an affiliated group are named insureds on a single surplus lines insurance contract, the home state as determined under subsection (3)(k)(i) or (3)(k)(ii) for the member of the affiliated group that has the largest percentage of premium attributed to it under the surplus lines insurance contract; or

(iv) if a group policyholder pays 100% of the premium from its own funds, the home state of the group policyholder as determined under subsection (3)(k)(i) or, if a group policyholder does not pay 100% of the premiums from its own funds, the home state of the group member as determined under subsection (3)(k)(i).

(l) "Independently procured insurance" means surplus lines insurance procured directly by an insured from an eligible surplus lines insurer.

(m) "Multistate risk" means a risk covered by an unauthorized insurer with insured exposures in more than one state.

(n) "Natural disaster multiperil insurance" means any combination of flood, earthquake, and landslide insurance that may be sold as surplus lines insurance.

(o) "Principal place of business" means the state where the insured business maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities of the insured.

(p) "Principal residence" means the state where an individual insured resides for the greatest number of days during a calendar year or, if the insured's principal residence is located outside of any state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is located.

(q) "Producing insurance producer" means a Montana-licensed property and casualty insurance producer dealing directly with a person seeking insurance.

(r) "Qualified risk manager" has the meaning provided in 33-2-319.

(s) "Single-state risk" means a risk covered by an unauthorized insurer with exposures in only one state.

(t) "State" means any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa.

(u) (i) "Surplus lines insurance" means any property, casualty, or inland marine insurance permitted in a state to be placed directly or through a surplus lines insurance producer with an unauthorized insurer eligible to accept the insurance. The term includes independently procured insurance.

(ii) The term does not include the kinds of insurance exempted under 33-2-317.

(v) "Surplus lines insurance producer" means an individual or business entity licensed under 33-2-305 to place surplus lines insurance on risks resident, located, or to be performed in this state with unauthorized insurers eligible to accept the insurance.

(w) "Unauthorized insurer" means, with respect to a state, an insurer not authorized to transact the business of insurance in the state. The term includes an insurance exchange authorized under the laws of another state. The term does not include a risk retention group, as that term is defined in the Liability Risk Retention Act of 1986, 15 U.S.C. 3901(a)(4).

History: En. Sec. 184, Ch. 286, L. 1959; R.C.M. 1947, 40-3409; amd. Sec. 1, Ch. 537, L. 1987; (3) En. Sec. 2, Ch. 537, L. 1987; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 8, Ch. 379, L. 1995; amd. Sec. 3, Ch. 271, L. 2009; amd. Sec. 1, Ch. 313, L. 2009; amd. Sec. 2, Ch. 350, L. 2011; amd. Sec. 1, Ch. 50, L. 2015; amd. Sec. 2, Ch. 48, L. 2019; amd. Sec. 1, Ch. 410, L. 2019; amd. Sec. 10, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 10, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-2-302. Home state exclusive authority — conditions precedent to sale of surplus lines insurance. (1) Pursuant to the Nonadmitted and Reinsurance Reform Act of 2010, Title V, subtitle B, of Public Law 111-203, the transaction of surplus lines insurance is subject to the statutory and regulatory requirements of the home state of the insured, regardless of whether a multistate risk is covered. If, at the time of the surplus lines insurance transaction, the home state:

(a) is Montana, the surplus lines insurance transaction is subject to the applicable statutory and regulatory requirements in Montana; or

(b) is not Montana, the Montana statutory and regulatory requirements regarding the surplus lines insurance transaction are preempted by the statutory and regulatory requirements of the home state.

(2) When Montana is the home state at the time of the surplus lines insurance transaction, the following apply:

(a) A producing insurance producer may request a surplus lines insurance producer to place or a surplus lines insurance producer may place a contract of insurance with an unauthorized insurer if:

(i) the insurer is an eligible surplus lines insurer;

(ii) the line of insurance or the full amount of the line of insurance cannot be obtained from authorized insurers or, in the case of a renewal, the line of insurance has not become available from an authorized insurer, as evidenced by one of the following:

(A) the producing insurance producer making a diligent effort to place the business with a minimum of three insurers authorized and actually transacting that line of business in this state. If fewer than three insurers are authorized and actually transacting the line of business in this state, diligent effort must be met by searching this lesser market.

(B) the appearance on the current approved risk list of the kind of insurance being sought; or

(C) the insurance is natural disaster multiperil insurance; and

(iii) all other requirements of this part are met.

(b) A producing insurance producer is not required to satisfy the search requirements in subsection (2)(a)(ii) if:

(i) the premium rate quoted by an authorized insurer is at least 10% higher than the premium rate quoted by an unauthorized insurer;

(ii) the unauthorized insurer is eligible under 33-2-307; and

(iii) the unauthorized insurer or the surplus lines insurance producer that placed the contract of insurance with the unauthorized insurer has provided the insured with disclosure information in a form and content approved by the commissioner.

(c) A producing insurance producer is not required to satisfy the search requirements in subsection (2)(a)(ii) if:

(i) the insured is an exempt commercial purchaser;

(ii) the producing insurance producer placing the coverage has disclosed to the exempt commercial purchaser that the insurance may or may not be available from an authorized insurer that may provide greater protection with more regulatory oversight; and

(iii) the exempt commercial purchaser has subsequently requested in writing to the producing insurance producer that the coverage be placed with the surplus lines insurer.

History: En. Secs. 185, 186, Ch. 286, L. 1959; R.C.M. 1947, 40-3410, 40-3411; amd. Sec. 1, Ch. 112, L. 1979; amd. Sec. 3, Ch. 537, L. 1987; amd. Sec. 1, Ch. 285, L. 1989; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 3, Ch. 451, L. 1993; amd. Sec. 9, Ch. 379, L. 1995; amd. Sec. 2, Ch. 191, L. 2005; amd. Sec. 5, Ch. 350, L. 2011; amd. Sec. 2, Ch. 50, L. 2015; amd. Sec. 3, Ch. 48, L. 2019.

Cross-References

Public examination of official documents, Art. II, sec. 9, Mont. Const.; 2-6-1003.

33-2-303. Filing and endorsement of contract — submission form. (1) Each insurance contract, cover note, or certificate of insurance procured and delivered as surplus lines insurance under this part, along with a submission form prescribed by the commissioner by rule, must be filed with:

(a) the commissioner if Montana is the home state of the insured and:

(i) the coverage is for a single-state risk; or

(ii) the commissioner has not entered an agreement pursuant to 33-2-323 for multistate risks;

(b) the clearinghouse, established pursuant to 33-2-323, if in operation and if the commissioner has entered an agreement pursuant to 33-2-323 for multistate risks.

(2) The commissioner shall establish by rule a submission form for reporting surplus lines transactions. The commissioner may establish different submission forms for insureds that

independently procured insurance, surplus lines insurance producers, single-state risks, and multistate risks. The submission form for surplus lines insurance producers must include:

(a) information regarding the producing producer's diligent efforts to place the coverage with authorized insurers and the results of the efforts; and

(b) the producing insurance producer's affirmation that the producer has expressly advised the insured prior to placing the insurance that:

(i) the surplus lines insurer with whom the insurance is placed is not authorized in this state and is not subject to the same supervision as an authorized insurer; and

(ii) in the event of the insolvency of the surplus lines insurer, the property and casualty guaranty fund of the state will not pay losses under the surplus lines coverage.

(3) A submission form filed under this section is subject to public inspection.

(4) The commissioner may establish by rule an endorsement to be made on each insurance contract, cover note, or certificate of insurance procured and delivered as surplus lines insurance by a surplus lines insurance producer under this part advising the insured that the coverage is issued by an unauthorized insurer that is not covered by the property and casualty guaranty fund of this state if the unauthorized insurer becomes insolvent. The surplus lines insurance producer shall properly fill in and sign the endorsement.

History: **En. Sec. 187, Ch. 286, L. 1959; R.C.M. 1947, 40-3412; amd. Sec. 4, Ch. 537, L. 1987; amd. Sec. 2, Ch. 285, L. 1989; amd. Sec. 9, Ch. 713, L. 1989; amd. Sec. 6, Ch. 350, L. 2011.**

Cross-References

Minimum policy language simplification standards, 33-15-325.

33-2-304. Surplus lines insurance valid. Insurance contracts procured as surplus lines insurance from unauthorized insurers in accordance with this law shall be fully valid and enforceable as to all parties and shall be given acceptance and recognition in all matters and respects to the same effect as like contracts issued by authorized insurers.

History: **En. Sec. 188, Ch. 286, L. 1959; R.C.M. 1947, 40-3413; amd. Sec. 5, Ch. 537, L. 1987.**

Cross-References

Exception to certificate of authority requirement, 33-2-102.

33-2-305. Licensing of surplus lines insurance producer — license fee. (1) If Montana is the home state of the insured, the person placing a contract of surplus lines insurance with an unauthorized insurer must possess a current surplus lines insurance producer's license issued by the commissioner.

(2) The commissioner shall issue licenses to persons to act as surplus lines insurance producers on either a resident or nonresident basis. To be eligible for a resident surplus lines insurance producer license, the person must hold a current property and casualty insurance producer license.

(3) Persons applying for a resident surplus lines insurance producer license shall:

(a) remit to the commissioner the fee prescribed by 33-2-708; and

(b) submit to the commissioner a completed license application in a form and manner approved by the commissioner.

(4) Persons applying for a nonresident surplus lines insurance producer license shall comply with 33-17-401.

(5) The licensee shall renew the license on a form prescribed by the commissioner. The commissioner may establish rules for biennial renewal of the license. A license lapses if not renewed.

(6) A business entity is eligible to be licensed as a surplus lines insurance producer if:

(a) the business entity license lists the individuals within the business entity who have satisfied the requirements of this part to become surplus lines insurance producers; and

(b) only those individuals listed on the business entity license transact surplus lines insurance.

(7) This section may not be construed to require agents, producers, or brokers acting as intermediaries between a surplus lines insurance producer and an unauthorized insurer under this part to hold a valid Montana surplus lines insurance producer's license.

(8) This section may not be construed to require a surplus lines insurance producer license for independently procured insurance.

(9) The commissioner may participate in the national association of insurance commissioners' producer licensing database regarding surplus lines insurance producer licensing.

History: En. Sec. 189, Ch. 286, L. 1959; R.C.M. 1947, 40-3414; amd. Sec. 6, Ch. 537, L. 1987; amd. Sec. 3, Ch. 285, L. 1989; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 1, Ch. 180, L. 1991; amd. Sec. 4, Ch. 451, L. 1993; amd. Sec. 10, Ch. 379, L. 1995; amd. Sec. 6, Ch. 427, L. 2003; amd. Sec. 3, Ch. 469, L. 2005; amd. Sec. 4, Ch. 271, L. 2009; amd. Sec. 2, Ch. 313, L. 2009; amd. Sec. 7, Ch. 350, L. 2011.

Cross-References

Licensure of insurance producers, Title 33, ch. 17, part 2.

33-2-306. Surplus lines insurance producer's authority under license — acceptance of business from other insurance producers. (1) Under a surplus lines insurance producer's license, the licensee may place surplus lines insurance, in compliance with this part, with a domestic surplus lines insurer or a foreign or alien insurer not authorized to transact insurance in this state and may act as a surplus lines insurance producer in this state for the insurer.

(2) The surplus lines insurance producer may accept surplus lines insurance from a licensed insurance producer of an authorized insurer or, if the commissioner agrees in advance, through an individual or business entity that has not been appointed as an insurance producer in this state and may provide compensation for the service, notwithstanding 33-17-1103.

(3) A surplus lines insurance producer who places or renews surplus lines insurance in accordance with subsection (1) may collect an inspection fee for the actual costs of inspecting the risk to be covered.

History: En. Sec. 190, Ch. 286, L. 1959; R.C.M. 1947, 40-3415; amd. Sec. 7, Ch. 537, L. 1987; amd. Sec. 4, Ch. 285, L. 1989; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 2, Ch. 180, L. 1991; amd. Sec. 1080, Ch. 56, L. 2009; amd. Sec. 5, Ch. 271, L. 2009; amd. Sec. 3, Ch. 313, L. 2009; amd. Sec. 11, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 11, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-2-307. Requirements for eligible surplus lines insurers — list of eligible surplus lines insurers. (1) If an unauthorized insurer is domiciled in any state, a surplus lines insurance producer may not place insurance with that unauthorized insurer unless, at the time of placement, the unauthorized insurer:

(a) is authorized to issue the same kind of property or casualty insurance in its domiciliary jurisdiction; and

(b) maintains capital and surplus or its equivalent under the laws of its state of domicile, which equals the greater of:

(i) the minimum capital and surplus requirements of 33-2-109 and 33-2-110; or

(ii) $15 million. An insurer possessing less than $15 million capital and surplus may satisfy the requirements of this subsection upon an affirmative finding of acceptability by the commissioner. The commissioner's finding must be based on factors that include:

(A) the quality of management, capital, and surplus of a parent company;

(B) company underwriting profit and investment income trends;

(C) market availability; and

(D) company record and reputation within the industry.

(2) The commissioner may not make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $4.5 million.

(3) If an unauthorized insurer is an alien insurer, a surplus lines insurance producer may not place insurance with that unauthorized insurer unless, at the time of placement, the unauthorized insurer appears on the national association of insurance commissioners' Quarterly Listing of Alien Insurers.

(4) A list of eligible surplus lines insurers must be published at least semiannually by the commissioner for a range of risks, including disability income insurance. This subsection does not require the commissioner to place or maintain the name of any unauthorized insurer on the list of eligible surplus lines insurers. An action may not lie against the commissioner or an employee of the commissioner for anything said in issuing the list of eligible surplus lines insurers referred to in this subsection.

(5) As used in this section, the following definitions apply:

(a) "Capital", as used in the financial requirements of this section, means funds invested in for stocks or other evidences of ownership.

(b) "Surplus", as used in the financial requirements of this section, means funds over and above liabilities and capital of the insurer for the protection of policyholders.

History: En. Sec. 191, Ch. 286, L. 1959; R.C.M. 1947, 40-3416; amd. Sec. 6, Ch. 303, L. 1981; amd. Sec. 8, Ch. 537, L. 1987; (4) En. Sec. 9, Ch. 537, L. 1987; amd. Sec. 2, Ch. 713, L. 1989; amd. Sec. 5, Ch. 451, L. 1993; amd. Sec. 11, Ch. 379, L. 1995; amd. Sec. 3, Ch. 531, L. 1997; amd. Sec. 22, Ch. 227, L. 2001; amd. Sec. 10, Ch. 380, L. 2003; amd. Sec. 8, Ch. 350, L. 2011; amd. Sec. 2, Ch. 410, L. 2019; amd. Sec. 2, Ch. 471, L. 2021.

33-2-308. Evidence of insurance — changes. (1) Upon placing surplus lines insurance, the surplus lines insurance producer shall promptly issue or deliver to the insured or the producing insurance producer evidence of the insurance, consisting either of the policy as issued by the insurer or, if the policy is not then available, a cover note or certificate of insurance signed or countersigned by the insurance producer. The cover note or certificate must show the subject, coverage, conditions, and term of the insurance, the premium charged and taxes collected from the insured, and the name and address of the insurer. If a direct risk is assumed by more than one insurer, the cover note or certificate must state the name and address and proportion of the entire direct risk assumed by each insurer.

(2) If after the issuance and delivery of any cover note or certificate there is a change as to the identity of the insurers or the proportion of the direct risk assumed by the insurer as stated in the original cover note or certificate or in any other material respect as to the insurance coverage evidenced by the cover note or certificate, the surplus lines insurance producer shall promptly issue or deliver to the insured a substitute cover note or certificate accurately showing the current status of the coverage and the insurers responsible under the coverage.

(3) If a policy issued by the insurer is not available upon placement of the insurance and the surplus lines insurance producer has issued and delivered a cover note or certificate as provided in subsection (2), upon request by the insured, the surplus lines insurance producer shall as soon as reasonably possible procure from the insurer its policy evidencing the insurance and deliver the policy to the insured in replacement of the cover note or certificate previously issued.

(4) A surplus lines insurance producer may not issue or deliver an evidence of insurance or purport to insure or represent that insurance will be or has been written by an eligible surplus lines insurer unless the surplus lines insurance producer has authority from the insurer to cause the risk to be insured or has received information from the insurer in the regular course of business that the insurance has been granted.

History: En. Sec. 192, Ch. 286, L. 1959; R.C.M. 1947, 40-3417; amd. Sec. 11, Ch. 537, L. 1987; amd. Sec. 5, Ch. 285, L. 1989; amd. Sec. 10, Ch. 713, L. 1989; amd. Sec. 1081, Ch. 56, L. 2009; amd. Sec. 20, Ch. 396, L. 2017.

33-2-309. Liability of insurer as to losses and unearned premiums. (1) As to a surplus lines risk that has been assumed by an unauthorized insurer pursuant to The Surplus Lines Insurance Law and if the premium on the surplus lines risk has been received by the surplus lines insurance producer who placed the insurance, in all questions arising under the coverage as between the insurer and the insured, the insurer is considered to have received the premium due to it for the coverage. The insurer is liable to the insured for losses covered by the insurance and for unearned premiums that may become payable to the insured upon cancellation of the insurance, whether or not in fact the surplus lines insurance producer is indebted to the insurer with respect to the insurance or for any other cause. This provision does not affect rights as between the insurer and the surplus lines insurance producer.

(2) A payment of premium to a surplus lines insurance producer acting for a person other than individually in negotiating, continuing, or reviewing a policy of insurance under this part is considered to be payment to the insurer, notwithstanding any conditions or stipulations that may be inserted in the policy or contract.

(3) Each unauthorized insurer assuming a surplus lines direct risk under The Surplus Lines Insurance Law is considered to have subjected itself to the terms of this section.

History: En. Sec. 193, Ch. 286, L. 1959; R.C.M. 1947, 40-3418; amd. Sec. 12, Ch. 537, L. 1987; amd. Sec. 6, Ch. 285, L. 1989; amd. Sec. 11, Ch. 713, L. 1989; amd. Sec. 1082, Ch. 56, L. 2009.

33-2-310. Records — tax and fee statement. (1) Each surplus lines insurance producer shall keep a separate record and account of all business transacted under the producer's license, including a copy of each daily report, if any, or of each policy, certificate of insurance, cover note, or other evidence of insurance issued or delivered by the producer. The records must be available for examination by the commissioner at any reasonable time within 5 years after the issuance of the surplus lines insurance to which it relates.

(2) By the reporting date established by the commissioner by rule, the surplus lines insurance producer shall file with the commissioner or with the clearinghouse if requested by the commissioner a tax and fee statement for the preceding reporting period. The commissioner shall establish by rule the content and form of the tax and fee statement that must include but is not limited to:

(a) name and principal residence of the insured or the address at which the insured maintains its principal place of business;

(b) a brief and general description of the risk or exposure insured and where located;

(c) name and home office address of each insurer providing the surplus lines insurance;

(d) amount of each surplus lines insurance policy, the premium rate, and the gross premium charged for the policy;

(e) date and term of the policy;

(f) amount of premium returned on each policy canceled or not taken;

(g) amount of tax and other sums to be collected from the insured;

(h) identity of the producing insurance producer; and

(i) additional information that the commissioner may reasonably require.

(3) If Montana is the home state of the insured, an insured that has independently procured insurance shall report the surplus lines insurance transaction to the commissioner or the clearinghouse if requested by the commissioner in a manner and format prescribed by the commissioner. The insured is responsible for payment of the taxes, stamping fees, and clearinghouse processing fees associated with the surplus lines insurance transaction and is subject to the penalties under this part for failure to timely pay the taxes and fees.

History: **En. Sec. 194, Ch. 286, L. 1959; R.C.M. 1947, 40-3419; amd. Sec. 13, Ch. 537, L. 1987; amd. Sec. 7, Ch. 285, L. 1989; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 1083, Ch. 56, L. 2009; amd. Sec. 9, Ch. 350, L. 2011.**

Cross-References

Reports, fees, and taxes, Title 33, ch. 2, part 7.

33-2-311. Tax on surplus lines insurance. (1) Except as provided in 33-2-323, when this state is the home state of the insured, the surplus lines insurance producer shall collect from the insured and pay to the commissioner a tax on premiums collected for surplus lines insurance transacted in this state. The amount of premiums collected and the tax rate must be computed in the same manner as provided in 33-2-705 as to premiums of authorized insurers, except that amounts collected from the insured specifically for applicable state and federal taxes in excess of the premium otherwise required, or fees imposed by the surplus lines insurance producer pursuant to 33-2-320, are not considered to be part of the premium for the purposes of the computation. Upon filing of the tax and fee statement referred to in 33-2-310, the surplus lines insurance producer shall pay to the commissioner the amount of tax owing as to surplus lines insurance business transacted by the surplus lines insurance producer during the preceding reporting period as well as the stamping fee on the premium payable by the insured regardless of whether the coverage includes risks or exposures partially located or to be performed in another state.

(2) Except as provided in 33-2-323, if this state is not the home state of the insured, the commissioner may not collect any tax or stamping fee regardless of whether the coverage includes risks or exposures partially located or to be performed in this state.

(3) The commissioner by rule shall establish procedures that provide for the collection and payment of premium taxes, as well as the reporting of premium tax and surplus lines insurance transaction data, in accordance with the provisions of the Nonadmitted and Reinsurance Reform Act of 2010, Title V, subtitle B, of Public Law 111-203, for payment of taxes on this state's portion of risks covered by surplus lines insurance policies transacted outside this state that cover risks with exposures both in this state and outside this state.

History: **En. Sec. 195, Ch. 286, L. 1959; R.C.M. 1947, 40-3420; amd. Sec. 2, Ch. 664, L. 1979; amd. Sec. 14, Ch. 537, L. 1987; amd. Sec. 2, Ch. 622, L. 1987; amd. Sec. 2, Ch. 713, L. 1989; amd. Sec. 1084, Ch. 56, L. 2009; amd. Sec. 10, Ch. 350, L. 2011; amd. Sec. 2, Ch. 223, L. 2015.**

33-2-312. Penalty for failure to file statement, pay tax, or pay stamping fee. (1) A surplus lines insurance producer or an insured that independently procured insurance that fails to file the tax and fee statement as required under 33-2-310 or to pay the taxes as required under 33-2-311 is liable for a penalty of up to $25 for each day of delinquency, commencing 30 calendar days after the due date established by the commissioner by rule. The tax and penalty may be recovered in an action instituted by the commissioner in the name of the state in any court of competent jurisdiction with the attorney general representing the commissioner. The penalty when collected, unless collected by a justice's court, must be paid to the commissioner, forwarded to the state treasurer, and placed to the credit of the general fund. The surplus lines insurance producer's license is also subject to revocation as provided in 33-2-313.

(2) If a surplus lines insurance producer or an insured that independently procured insurance does not pay the stamping fee provided for in 33-2-321, the commissioner may impose a penalty of 25% of the stamping fee due plus 1.5% a month from the time of delinquency until the stamping fee is paid.

History: **En. Sec. 196, Ch. 286, L. 1959; R.C.M. 1947, 40-3421; amd. Sec. 15, Ch. 537, L. 1987; amd. Sec. 20, Ch. 557, L. 1987; amd. Sec. 8, Ch. 285, L. 1989; amd. Sec. 2, Ch. 713, L. 1989; amd. Sec. 6, Ch. 451, L. 1993; amd. Sec. 11, Ch. 350, L. 2011; amd. Sec. 9, Ch. 157, L. 2023.**

Cross-References

Duties of Attorney General, 2-15-501.

Collection and disposition of fines, penalties, forfeitures, and fees, 3-10-601.

33-2-313. Revocation or suspension of license. (1) The commissioner shall revoke or suspend any surplus lines insurance producer's license, together with any license as an insurance producer:

(a) if the insurance producer fails to file a tax and fee statement or to remit the tax and fee as required by law;

(b) if the insurance producer fails to keep the records or to allow the commissioner to examine the records, as required by law;

(c) if the insurance producer falsifies the submission form required by 33-2-310;

(d) if the insurance producer closes the surplus lines insurance producer office for a period of more than 30 business days, unless the commissioner grants permission otherwise;

(e) if the insurance producer violates any provision of this part; or

(f) for any of the causes for which an insurance producer's license may be revoked.

(2) The procedures provided by 33-17-1001 for the suspension, revocation, or refusal to license or renew a license or for imposing a fine on an insurance producer or applicant apply to the suspension, revocation, or refusal to license or renew a license or to imposing a fine on a surplus lines insurance producer or applicant.

(3) An insurance producer whose license has been revoked or suspended may not again be licensed within 1 year after revocation or suspension or until the insurance producer pays all penalties and delinquent taxes that are owed.

History: **En. Sec. 197, Ch. 286, L. 1959; R.C.M. 1947, 40-3422; amd. Sec. 16, Ch. 537, L. 1987; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 7, Ch. 451, L. 1993; amd. Sec. 23, Ch. 227, L. 2001; amd. Sec. 12, Ch. 350, L. 2011.**

Cross-References

Records required, 33-2-310.

Tax to be remitted, 33-2-311.

Insurance producer's license — grounds for revocation, 33-17-1001.

33-2-314. Actions against insurer — venue. Every unauthorized insurer issuing a surplus lines insurance policy under this part is considered to be doing business in this state as an unauthorized insurer and may be sued in this state upon any cause of action arising under any insurance contract so made by it. Such suit must be brought in the district court of the county wherein the plaintiff resides.

History: **En. Sec. 198, Ch. 286, L. 1959; R.C.M. 1947, 40-3423; amd. Sec. 17, Ch. 537, L. 1987.**

Cross-References

Unauthorized Insurers Process Act, 33-1-611 through 33-1-616.

33-2-315. Service of process. (1) Every surplus lines insurer before transacting surplus lines insurance under this part shall designate a registered agent with the commissioner as provided in 33-1-605.

(2) Service upon such an insurer must be made pursuant to 33-1-605 or 33-1-606.

History: En. Sec. 199, Ch. 286, L. 1959; R.C.M. 1947, 40-3424; amd. Sec. 18, Ch. 537, L. 1987; amd. Sec. 6, Ch. 60, L. 2019.

33-2-316. Rules. The commissioner shall make reasonable rules, consistent with this part, for any of the following purposes:

(1) effectuation of The Surplus Lines Insurance Law; and

(2) establishment of procedures through which determination is to be made as to the eligibility of particular proposed coverages for placement with a surplus lines insurer or insurers.

History: En. Sec. 200, Ch. 286, L. 1959; R.C.M. 1947, 40-3425; amd. Sec. 20, Ch. 537, L. 1987; amd. Sec. 9, Ch. 285, L. 1989; amd. Sec. 12, Ch. 713, L. 1989; amd. Sec. 24, Ch. 227, L. 2001; amd. Sec. 13, Ch. 350, L. 2011.

Cross-References

Montana Administrative Procedure Act — promulgation of rules, Title 2, ch. 4.
Promulgation of rules by Commissioner, 33-1-313.

33-2-317. Exemptions. The Surplus Lines Insurance Law does not apply to reinsurance or to the following kinds of insurance when placed by a licensed insurance producer of this state:

(1) wet marine insurance;

(2) insurance on property or operations of railroads engaged in interstate commerce; and

(3) insurance of aircraft owned or operated by manufacturers of aircraft or aircraft operated in scheduled interstate flight or cargo of the aircraft or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of the aircraft.

History: En. Sec. 201, Ch. 286, L. 1959; R.C.M. 1947, 40-3426; amd. Sec. 21, Ch. 537, L. 1987; amd. Sec. 10, Ch. 285, L. 1989; amd. Sec. 13, Ch. 713, L. 1989; amd. Sec. 4, Ch. 531, L. 1997; amd. Sec. 14, Ch. 350, L. 2011.

33-2-318. Exempt commercial purchaser defined. (1) An exempt commercial purchaser means an individual or business entity who at the time of placement:

(a) employs or retains a qualified risk manager to negotiate insurance coverage;

(b) has paid aggregate nationwide commercial property and casualty insurance premiums in excess of $100,000 in the immediately preceding 12 months; and

(c) meets at least one of the following criteria:

(i) possesses a net worth in excess of $20 million, as that amount may be adjusted pursuant to subsection (2);

(ii) generates annual revenue in excess of $50 million, as that amount may be adjusted pursuant to subsection (2);

(iii) employs more than 500 full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than 1,000 employees in the aggregate;

(iv) is a not-for-profit organization or a public entity generating annual budgeted expenditures of at least $30 million, as that amount may be adjusted pursuant to subsection (2); or

(v) is a municipality with a population in excess of 50,000 persons.

(2) Effective January 1, 2015, and on every 5th subsequent January 1, the amounts in subsections (1)(c)(i), (1)(c)(ii), and (1)(c)(iv) must be adjusted to reflect the percentage of change for that 5-year period in the consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor.

History: En. Sec. 3, Ch. 350, L. 2011.

33-2-319. Qualified risk manager defined. (1) A qualified risk manager means a person who:

(a) is an employee of or a third-party consultant retained by the commercial policyholder;

(b) provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis and purchases of insurance; and

(c) has the qualifications specified in subsection (2).

(2) To be a qualified risk manager, a person must have:

(a) (i) a bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the commissioner to demonstrate minimum competence in risk management; and

(ii) (A) 3 years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis, or purchasing commercial lines of insurance; or

(B) one of the following designations:

(I) a designation as a chartered property and casualty underwriter (CPCU) issued by the American institute for CPCU/insurance institute of America;

(II) a designation as an associate in risk management issued by the American institute for CPCU/insurance institute of America;

(III) a designation as certified risk manager issued by the national alliance for insurance education and research;

(IV) a designation as a risk and insurance management society fellow issued by the global risk management institute;

(V) any other designation, certification, or license determined by the commissioner to demonstrate minimum competency in risk management;

(b) (i) at least 7 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and

(ii) any one of the designations specified in subsection (2)(a)(ii)(B);

(c) at least 10 years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

(d) a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by the commissioner to demonstrate minimum competence in risk management.

History: En. Sec. 4, Ch. 350, L. 2011.

33-2-320. Surplus lines insurance producer fee. (1) A surplus lines insurance producer may collect a flat fee per policy for business placed in the surplus lines insurance market. The fee may not exceed:

(a) $50 for a personal lines insurance policy; or

(b) $100 for a commercial lines insurance policy.

(2) The fees allowed under this section are not considered part of the premium charged to the insured and do not fall within the definition of premium provided in 33-15-102.

(3) The fees allowed under this section apply only to surplus lines insurance producers transacting surplus lines insurance business.

History: En. Sec. 1, Ch. 223, L. 2015.

33-2-321. Stamping fee and clearinghouse processing fee. (1) The commissioner may collect a stamping fee not to exceed 1% of the premium payable for surplus lines insurance transacted in this state. The commissioner shall establish the stamping fee by rule commensurate with the expenses of regulating surplus lines. The stamping fee must be placed in a state special revenue account to the credit of the commissioner's office and used for the expenses of the commissioner's office in regulating surplus lines insurance.

(2) If the commissioner has entered an agreement with a clearinghouse as authorized pursuant to 33-2-323 to process multistate risks and allocate and distribute taxes and fees collected, the clearinghouse may collect a processing fee from the surplus lines insurance producer or the insured that independently procured insurance. The processing fee may be a flat fee per submission, a percentage of the premium payable for surplus lines insurance, or a combination of a flat fee and a percentage of premium payable. When a percentage of premium payable is used in calculating the processing fee, the charge may not exceed 1% of the premium payable for surplus lines insurance. The commissioner shall establish the processing fee by rule to be commensurate with the clearinghouse's charges to process multistate risks and allocate and distribute taxes and fees collected to the participating states.

(3) If applicable, the surplus lines insurance producer shall collect the stamping fee and clearinghouse processing fee from the insured in addition to the premium payable for the insurance contract and any taxes and fees.

History: **En. Sec. 10, Ch. 537, L. 1987; amd. Sec. 11, Ch. 285, L. 1989; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 1, Ch. 184, L. 2001; amd. Sec. 15, Ch. 350, L. 2011.**

33-2-322. Repealed. Sec. 54, Ch. 157, L. 2023.
History: **En. Sec. 16, Ch. 350, L. 2011.**

33-2-323. Authorization for agreements with other state regarding multistate risks. (1) Following negotiated rulemaking under Title 2, chapter 5, the commissioner may enter into a cooperative or reciprocal agreement with other states, individually or collectively, for the purposes of collecting, allocating, and disbursing premium taxes and fees attributable to multistate risks. The allocation methodology of any agreement must be based upon readily available data, with simplicity and uniformity for the surplus lines insurance producer as a material consideration. Any agreement regarding multistate risks may require that a single, blended tax rate be used.

(2) An agreement entered into under this section must provide for:

(a) uniform eligibility standards for unauthorized insurers;

(b) uniform methods for reporting surplus lines insurance transactions and sharing information between the parties to the agreement based upon readily available data;

(c) uniform methods for allocating and reporting surplus lines insurance risk classifications based upon readily available data;

(d) uniform procedures for the collection, allocation, and distribution of taxes and fees attributable to the multistate risks;

(e) uniform disclosures to policyholders regarding the reporting and collection of premium taxes on multistate risks;

(f) an allocation methodology and resulting collection of premium tax revenue, less costs of administration and collection, that generate premium tax revenue not less than the premium tax revenue collected under 33-2-311;

(g) minimizing the data collection and reporting burden on insureds and surplus lines insurance producers;

(h) a withdrawal process that minimizes instability among the participating states and the surplus lines and insurance industries;

(i) regulatory provisions that provide certainty regarding compliance to all persons having an interest in surplus lines insurance transactions, including but not limited to insureds, regulators, surplus lines insurance producers, other insurance producers, and surplus lines insurers; and

(j) continued collection of premium taxes under 33-2-311 until the collection infrastructure under the agreement is fully operational and the provisions of the agreement are fully implemented.

(3) If the commissioner has entered into an agreement under subsection (1) for multistate risks and the agreement provides that each participating state develop a single, blended tax rate for multistate risks:

(a) the provisions of 50-3-109 are not applicable to the collection of premium taxes;

(b) the single, blended tax rate must be 3.3% on premiums and must be computed in the manner provided in 33-2-705(1) as to premiums of authorized insurers, except that amounts collected from the insured specifically for applicable state and federal taxes and in excess of the premium otherwise required are not considered to be part of the premium for the purposes of the computation; and

(c) the 3.3% tax collected must be distributed as follows:

(i) 2.75% must be considered premium taxes as provided in 33-2-705 and paid to the state general fund; and

(ii) 0.55% must be considered fire premium taxes as provided in 50-3-109 and paid to the state general fund.

(4) If a single-state risk is involved and Montana is the home state of the insured, the surplus lines transaction must be submitted to the commissioner and the commissioner shall collect the tax at the same rate and in the same manner as provided in 33-2-705.

(5) If the commissioner has entered into a cooperative or reciprocal agreement under subsection (1), the commissioner may contract with the designated clearinghouse to process multistate risks and allocate and distribute taxes and fees collected.

(6) As used in this section, "readily available data" means Montana-specific data, if any, used to rate a surplus lines insurance policy.

History: **En. Sec. 17, Ch. 350, L. 2011.**

33-2-324. Insurance presumed unobtainable from authorized insurers. At least annually, the commissioner shall make available a list of the kinds of insurance that are presumed to be unobtainable from authorized insurers, known as the approved risk list.

History: **En. Sec. 8, Ch. 157, L. 2023.**

33-2-325. Designation as a domestic surplus lines insurer — requirements — scope of business activity permitted. (1) A domestic insurer possessing minimum capital and surplus of at least $15 million, pursuant to a resolution by its board of directors and on the written approval of the commissioner, may be designated as a domestic surplus lines insurer. A domestic surplus lines insurer must be considered an unauthorized insurer only for the purposes of writing surplus lines insurance coverage pursuant to the requirements of this section.

(2) A domestic surplus lines insurer shall only write surplus lines insurance in this state procured pursuant to the requirements of this title. A domestic surplus lines insurer may write surplus lines insurance in any other jurisdiction in which the insurer is eligible to write surplus lines insurance if the domestic surplus lines insurer complies with any requirements of that jurisdiction.

(3) Insurance written by a domestic surplus lines insurer is subject to the tax on premiums required by 33-2-311 and is exempt from the tax on premiums required by 33-2-705.

(4) A domestic surplus lines insurer must be considered a nonadmitted insurer as referenced in 15 U.S.C. 8206 with respect to surplus lines insurance issued in this state.

(5) Surplus lines insurance policies issued in this state by a domestic surplus lines insurer are not subject to the protection or other provisions of the Montana Insurance Guaranty Association Act, Title 33, chapter 10, part 1.

(6) Surplus lines insurance policies issued in this state by a domestic surplus lines insurer are not subject to and are exempt from all statutory requirements relating to insurance rating and rating plans, policy forms, and policy cancellation and nonrenewal in the same manner and to the same extent as a surplus lines insurer domiciled in another state.

History: **En. Sec. 9, Ch. 8, L. 2025.**

Compiler's Comments

Effective Date: Section 37, Ch. 8, L. 2025, provided that this section is effective October 1, 2025.

33-2-326. Penalties. A surplus lines insurance producer who in this state represents or aids an unauthorized insurer in violation of this part is subject to the penalties and procedures in 33-1-317 and 33-1-318.

History: **En. Sec. 19, Ch. 537, L. 1987; amd. Sec. 2, Ch. 713, L. 1989; amd. Sec. 11, Ch. 380, L. 2003.**

Part 4
Standard Valuation

33-2-401. Short title. This part may be cited as the "Standard Valuation Act".

History: **En. Sec. 10, Ch. 370, L. 2015.**

33-2-402. Definitions. As used in this part, the following definitions apply unless the context clearly indicates otherwise:

(1) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions.

(2) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare an actuarial opinion required by this part.

(3) "Deposit-type contract" means a contract that does not incorporate mortality or morbidity risks.

(4) "Insurer" means an entity that:

(a) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in Montana and has at least one of the named contracts in force or on claim; or

(b) has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in Montana.

(5) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts.

(6) "NAIC" means the national association of insurance commissioners.

(7) (a) "Policyholder behavior" means any action taken by a policyholder, a contract holder, or any other person with the right to elect options, such as the action that a certificate holder may take under a policy or a contract subject to this part. The actions include but are not limited to allowing a policy or contract to lapse, making a premium payment or loan, or making benefit elections prescribed by the policy or contract. Other actions may be identified by rule.

(b) The term does not include events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(8) "Principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer. A principle-based valuation must comply with the provisions of 33-2-404.

(9) "Qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American academy of actuaries qualification standards and meets the requirements specified in the valuation manual.

(10) "Tail risk" means a risk that occurs either when the frequency of low-probability events is higher than expected under a normal probability distribution or when there are observed events of very significant size or magnitude.

(11) "Valuation manual" means the valuation manual adopted by the NAIC in accordance with its model law regarding standard valuation and adopted by the commissioner by rule.

History: **En. Sec. 11, Ch. 370, L. 2015.**

33-2-403. Valuation for policies. (1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under 33-2-407, except as provided in subsection (6) or (8) of this section.

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(a) the valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members or three-fourths of the members voting, whichever is greater;

(b) the standard valuation law as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health, health, and fraternal annual statements;

(c) the standard valuation law as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 of the following 55 jurisdictions: the 50 states of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico; and

(d) the commissioner has adopted by rule the valuation manual.

(3) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual are effective on January 1 following the date when all of the following have occurred:

(a) the change in the valuation manual has been adopted by an affirmative vote representing:

(i) at least three-fourths of the members of the NAIC voting but not less than a majority of the total membership; and

(ii) members of the NAIC representing jurisdictions totaling more than 75% of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subsection (3)(a)(i): life, accident and health, health, and fraternal annual statements; and

(b) the change to the valuation manual is adopted by the commissioner by rule.

(4) The valuation manual adopted by the commissioner must specify all of the following:

(a) minimum valuation standards for and definitions of the policies or contracts subject to 33-2-407(2). The minimum valuation standards include:

(i) the commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to 33-2-404;

(ii) the commissioner's annuity reserve valuation method for annuity contracts subject to 33-2-407(2); and

(iii) minimum reserves for all other policies or contracts subject to 33-2-404(2).

(b) a description of the policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in 33-2-404(1) and the minimum valuation standards consistent with those requirements;

(c) for policies and contracts subject to a principle-based valuation:

(i) requirements for the format of reports to the commissioner under 33-2-404(3)(c), which must include information necessary to determine if the valuation is appropriate and in compliance with this part;

(ii) prescribed assumptions for risks over which the company does not have significant control or influence; and

(iii) procedures for corporate governance and oversight of the actuarial function as well as a process for appropriate waiver or modification of the corporate governance procedures.

(d) for policies not subject to a principle-based valuation under 33-2-404, the minimum valuation standard must either:

(i) be consistent with the minimum standard of valuation prior to the operative date of the valuation manual as determined in subsections (1) and (2) or as amended as provided in subsection (3); or

(ii) develop reserves that quantify the benefits and guarantees as well as the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring; and

(e) other components in the valuation manual that the commissioner considers necessary for the smooth operation of policies or contracts under this part. These may include but are not limited to reserve methodologies, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules, and internal controls.

(5) The commissioner shall specify by rule the data and form of the data required under 33-2-405 and to whom the data must be submitted as well as any other requirements including data analysis and reporting of analysis.

(6) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this part, the company shall, with respect to the requirements named as out of compliance with this part, comply with minimum standard valuations prescribed by the commissioner by rule.

(7) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and comment on the appropriateness of any reserve assumption or method used by the company or to review and comment on a company's compliance with any requirement in this part. The commissioner may rely on the opinion, regarding provisions contained in this part, of a qualified actuary engaged by the insurance regulator of another state, district, or territory of the United States. As used in this subsection, the term "engage" includes employment and contracting.

(8) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or of this part.

(9) A company shall adjust its reserves as required by the commissioner.

(10) The commissioner may take disciplinary action for violations of this section as provided in 33-1-317.

History: En. Sec. 12, Ch. 370, L. 2015.

33-2-404. Principle-based valuation. (1) A company domiciled in Montana shall establish reserves using a principle-based valuation that meets the conditions for policies or contracts in this section and as specified in the valuation manual.

(2) The principle-based valuation at a minimum must:

(a) quantify the benefits and guarantees as well as the funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. The principle-based valuation method must reflect conditions appropriately adverse to quantify the tail risk for policies and contracts with significant tail risk.

(b) incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with but not necessarily identical to those used within the company's overall risk assessment process. This process must recognize potential differences in financial reporting structures and any prescribed assumptions or methods.

(c) incorporate assumptions derived:

(i) as prescribed in the valuation manual; or

(ii) if not prescribed in the valuation manual, using:

(A) the company's available experience to the extent the experience is relevant and statistically credible; or

(B) other relevant and statistically credible experience whenever the company's own data is not available, relevant, or statistically credible; and

(d) provide margins for uncertainty, including adverse deviation and estimation error to the extent that the greater the uncertainty, the larger the margin and resulting reserve.

(3) A company using principle-based valuation for one or more policies or contracts subject to this section and as specified in the valuation manual shall:

(a) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(b) provide to the commissioner and its board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. These internal controls must be designed to ensure that all material risks inherent in the liabilities and associated assets subject to the principle-based valuation are included in the valuation and are performed in accordance with the valuation manual. The certification must be based on controls in place as of the end of the preceding calendar year.

(c) develop a principle-based valuation report that complies with standards prescribed in the valuation manual. This report must be filed with the commissioner upon the commissioner's request. A report under this subsection (3)(c) is required after the commissioner has adopted rules as provided in 33-2-418.

(4) A principle-based valuation may include a prescribed formulaic reserve component.

History: En. Sec. 13, Ch. 370, L. 2015.

33-2-405. Experience reporting. A company shall submit mortality, morbidity, policyholder behavior, expense experience, and other data as prescribed by the commissioner and in accordance with the valuation manual.

History: En. Sec. 14, Ch. 370, L. 2015.

33-2-406. Confidentiality — definitions. (1) Except as provided in subsection (9), a company's confidential information is confidential information as provided in 2-6-1002 and privileged, is not subject to subpoena or discovery, and is not admissible in evidence in any private civil action.

(2) The commissioner may use the confidential information to further any regulatory or legal action brought against the company as a part of the commissioner's official duties.

(3) Neither the commissioner nor any person who receives confidential information while acting under the authority of the commissioner may be required or permitted to testify in any private civil action concerning a company's confidential information.

(4) Subject to the conditions in subsection (4)(c), the commissioner may, to assist in the performance of the commissioner's duties, share:

(a) confidential information with other state, federal, and international regulatory agencies and with the NAIC and its affiliates and subsidiaries upon agreement that the confidential information will be kept confidential; and

(b) only confidential information as defined in subsections (10)(a)(i)(A) and (10)(a)(i)(D) with:

(i) the actuarial board for counseling and discipline or its successor upon a request that states the confidential information is required for use in professional disciplinary proceedings; and

(ii) state, federal, and international law enforcement officials; and

(c) the information under this subsection (4) only if the recipient of the information has the legal authority to agree, and the recipient has agreed, to maintain the confidentiality and privileged status of the documents, materials, data, and other information in the same manner and to the same extent as required for the commissioner.

(5) (a) The commissioner may receive documents, materials, data, and other information, including otherwise confidential and privileged documents, materials, data, and other information, from:

(i) the NAIC and its affiliates and subsidiaries;

(ii) regulatory or law enforcement officials of other foreign or domestic jurisdictions; and

(iii) the actuarial board for counseling and discipline or its successor.

(b) The commissioner shall maintain as confidential or privileged any documents, materials, data, or other information received from the entities listed in subsection (5)(a) with notice or the understanding that the documents, materials, data, or other information is confidential or privileged under the laws of the jurisdiction that is the source of the documents, materials, data, or other information.

(6) The commissioner may enter into agreements governing the sharing and use of confidential information consistent with this section.

(7) A disclosure to the commissioner under this section or a sharing of confidential information authorized in this section does not constitute a waiver of any applicable privilege or claim of confidentiality for the confidential information.

(8) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section must be recognized and enforced in any proceeding in this state, including any court proceedings.

(9) The confidential information defined in subsections (10)(a)(i)(A) and (10)(a)(i)(D) may:

(a) be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under 33-2-407 or a principle-based valuation report developed pursuant to 33-2-404(3)(c) by reason of an action required by this part;

(b) be otherwise released by the commissioner with the written consent of the company; or

(c) no longer be confidential for all portions after any portion of a memorandum in support of an opinion submitted under 33-2-407 or a principle-based valuation report developed under 33-2-404(3)(c) is cited by the company in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the company to the news media.

(10) As used in this section, the following definitions apply:

(a) (i) "Confidential information" means:

(A) a memorandum in support of an opinion submitted under 33-2-407 and any other documents, materials, and other information, including but not limited to all working papers or copies of the working papers that were created, produced, or obtained by the commissioner or by any other person in connection with the memorandum or disclosed to the commissioner or to any other person in connection with the memorandum;

(B) subject to the provisions of subsection (10)(a)(ii)(A), all documents, materials, and other information in the course of an examination made under 33-2-403(7), including but not limited to all working papers and copies of the working papers that were created, produced, or obtained by the commissioner or by any other person in connection with the examination or disclosed to the commissioner or to any other person in connection with the examination;

(C) any reports, documents, materials, or other information developed by a company in support of or in connection with an annual certification by the company under 33-2-404(3)(b) evaluating the effectiveness of the company's internal controls with respect to a principle-based valuation and any other documents, materials, and other information, including but not limited to working papers and copies of the working papers created, produced, or obtained by the commissioner or by any other person in connection with the reports, documents, materials, and other information disclosed to the commissioner or to any other person in connection with those reports, documents, materials, and other information;

(D) any principle-based valuation report developed under 33-2-404(3)(c) and any other documents, materials, and other information, including but not limited to all working papers and copies of working papers created, produced, or obtained by the commissioner or any other person in connection with the principle-based valuation report or disclosed to the commissioner or to any other person in connection with the report; and

(E) any experience data and any other documents, materials, data, and other information, including but not limited to all working papers and copies of working papers created or produced in connection with the experience data. The information under this subsection (10)(a)(i)(E) includes any potential company-identifying or personally identifiable information that is provided to or obtained by the commissioner or any other person in connection with the documents, materials, data, and other information described in this subsection (10)(a)(i)(E), including but not limited to working papers and copies of working papers created, produced, or obtained by the commissioner or any other person or disclosed to the commissioner or to any other person.

(ii) The term does not include:

(A) an examination report or other material prepared in connection with an examination made under 33-2-403(7) to the extent that the examination report or other material prepared in connection with the examination would not have been held private and confidential if prepared under 33-1-401; or

(B) any portion of confidential information that has been cited by the insurer in its marketing, provided to any governmental agency other than a state insurance department, released by the insurer to the news media, or otherwise made public by the insurer in any way.

(b) "Experience data" means any documents, materials, data, and other information submitted by a company under 33-2-405.

(c) "NAIC" means the national association of insurance commissioners and its employees, agents, consultants, and contractors.

(d) "Regulatory agency" includes the agency's employees, agents, consultants, and contractors.

History: En. Sec. 15, Ch. 370, L. 2015; amd. Sec. 69, Ch. 348, L. 2015.

33-2-407. Standard valuation of reserve liabilities law. (1) The commissioner shall annually value or cause to be valued the reserve liabilities (reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurer doing business in this state issued on or before the operative date of the valuation manual. In calculating the reserves under this subsection, the commissioner may use group methods and approximate averages for fractions of a year or otherwise.

(2) The commissioner shall annually value or cause to be valued the reserve liabilities for all outstanding life insurance contracts, annuities, and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued after the operative date of the valuation manual in accordance with the valuation manual.

(3) In lieu of the valuation of the reserves required in this section of any foreign or alien insurer, the commissioner may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this part.

(4) Any insurer that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standards provided in this part may, with the approval of the commissioner, adopt any lower standard of valuation but not lower than the minimum in this section. For the purposes of this section, the holding of additional reserves previously determined by an appointed actuary to be necessary to render the opinion required in subsections (5) and (6) may not be considered to be the adoption of a higher standard of valuation.

(5) (a) Each life insurer doing business in this state prior to the operative date of the valuation manual shall annually submit the opinion of a qualified actuary as to whether the

reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered necessary to its scope.

(b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by subsection (5)(a) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. In developing the opinion, the qualified actuary shall consider the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts.

(c) The commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may consider necessary in order to render the opinion required by this subsection (5).

(d) Each opinion required by this subsection (5) must be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the commissioner as specified by rule, must be prepared to support each actuarial opinion.

(ii) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or if the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the rules or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and to prepare any supporting memorandum as is required by the commissioner.

(iii) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1996.

(iv) The opinion must apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(v) The opinion must be based on standards adopted from time to time by the actuarial standards board and on additional standards as the commissioner may prescribe by rule.

(vi) In the case of an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(viii) Disciplinary action by the commissioner against the insurer or the qualified actuary must be defined in rules by the commissioner.

(6) (a) After the operative date of the valuation manual, each life insurer doing business in this state shall annually submit the opinion of a qualified actuary regarding whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are:

(i) computed appropriately;

(ii) based on assumptions that satisfy contractual provisions;

(iii) consistent with prior reported amounts; and

(iv) in compliance with the applicable laws of this state.

(b) After the operative date of the valuation manual, each life insurer doing business in this state shall also annually include in the opinion required in subsection (6)(a) an opinion by the same qualified actuary on whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual make adequate provision for the company's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts. The opinion required in this subsection (6)(b) must consider the reserves and related actuarial items in light of the assets held by the company with respect to those reserves and related actuarial items, including but not limited to the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts.

(c) A qualified actuary shall prepare a memorandum in support of each actuarial opinion under this subsection (6). The memorandum must be in the form and substance specified in the valuation manual and as provided by the commissioner.

(d) The opinion under this subsection (6):

(i) must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after the operative date of the valuation manual;

(ii) must apply to all policies and contracts subject to this subsection (6) and to other actuarial liabilities identified in the valuation manual; and

(iii) must be based on the actuarial standards board's standards and any additional standards prescribed in the valuation manual.

(e) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or if the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(f) For an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state.

(g) (i) Except as provided in subsection (6)(g)(iii), the appointed actuary is not liable for damages to any person other than the insurer and the commissioner for any act, error, omission, decision, or conduct with respect to the appointed actuary's opinion.

(ii) The provisions of subsection (6)(g)(i) do not apply in cases of fraud or willful misconduct.

(h) The commissioner shall define by rule any disciplinary action that may be taken by the commissioner against the insurer or the appointed actuary.

History: En. Sec. 92, Ch. 286, L. 1959; amd. Sec. 1, Ch. 61, L. 1961; amd. Sec. 1, Ch. 41, L. 1965; amd. Sec. 1, Ch. 341, L. 1973; R.C.M. 1947, 40-3011(1); amd. Sec. 13, Ch. 379, L. 1995; amd. Sec. 14, Ch. 472, L. 1999; amd. Sec. 17, Ch. 370, L. 2015; Sec. 33-2-521, MCA 2013; redes. 33-2-407 by Sec. 40, Ch. 370, L. 2015; amd. Sec. 3, Ch. 471, L. 2021.

33-2-408. Contracts prior to the operative date of 33-20-213 — valuation. (1) This section shall apply to only those policies and contracts issued prior to the operative date of 33-20-213.

(2) Except as otherwise provided in 33-2-410 for group annuity and pure endowment contracts, the minimum standard of valuation on all policies of domestic life insurers issued prior to January 1, 1922, shall be the American experience table of mortality and interest at 3½% per annum, with preliminary term insurance for the first policy year, and for policies of such insurers issued subsequent to December 31, 1921, shall be the American experience table of mortality with interest at 3½% per annum, with preliminary term insurance for the first policy year, except as follows: If the premium charged for term insurance under a limited payment life preliminary term policy providing for the payment of all premiums thereon in less than 20 years from the date of the policy or under an endowment preliminary term policy exceeds that charged for life insurance under 20-payment life preliminary term policies of the same insurer, the reserve thereon at the end of any year, including the first, shall not be less than the reserve on a 20-payment life preliminary term policy issued in the same year and at the same age, together with an amount which shall be equivalent to the accumulation of a net level premium reserve sufficient to provide for a pure endowment at the end of the premium payment period equal to the difference between the value at the end of such period of such a 20-payment life preliminary term policy and the full net level premium reserve at such time of such a limited payment life or endowment policy.

(3) Reserves for all such policies and contracts may be calculated, at the option of the insurer, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by this section.

History: **En. Sec. 92, Ch. 286, L. 1959; amd. Sec. 1, Ch. 61, L. 1961; amd. Sec. 1, Ch. 41, L. 1965; amd. Sec. 1, Ch. 341, L. 1973; R.C.M. 1947, 40-3011(2); Sec. 33-2-522, MCA 2013; redes. 33-2-408 by Sec. 40, Ch. 370, L. 2015.**

33-2-409. Contracts on or after operative date of 33-20-213 and prior to operative date of valuation manual — valuation. (1) This section applies to only those policies and contracts issued prior to the date of adoption of the valuation manual, which is the operative date for the valuation manual, and on or after the operative date of 33-20-213, except as otherwise provided in 33-2-410 for group annuity and pure endowment contracts issued prior to that date.

(2) Except as otherwise provided in 33-2-410, 33-2-411, and 33-2-417(2), the minimum standard for the valuation of all the policies and contracts issued prior to October 1, 1995, is the standard provided by the laws in effect prior to October 1, 1995. Except as otherwise provided in 33-2-410, 33-2-411, and 33-2-417(2), the minimum standard for the valuation of all policies and contracts issued prior to the operative date of the valuation manual, as provided in subsection (1) of this section, is the commissioner's reserve valuation methods defined in 33-2-411, 33-2-412(3) and (4), and 33-2-417, 5% interest for group annuity and pure endowment contracts, and 3½% interest for all other policies and contracts or, in the case of life insurance policies and contracts other than annuity and pure endowment contracts issued on or after March 17, 1973, 4% interest for all other policies issued prior to July 1, 1979, 5½% interest for single-premium life insurance policies, and 4½% interest for all other policies issued on or after July 1, 1979, and the following tables:

(a) for all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in the policies:

(i) the 1941 commissioners standard ordinary mortality table for policies issued prior to the operative date of 33-20-206, as amended, and the 1958 commissioners standard ordinary mortality table for policies issued on or after that operative date but prior to January 1, 1989, except that for any category of the policies issued on female risks, modified net premiums and present values, referred to in 33-2-411 and 33-2-412, may be calculated, at the option of the insurer, with the approval of the commissioner, according to an age younger than the actual age of the insured;

(ii) for policies issued prior to the operative date of the valuation manual but on or after January 1, 1989:

(A) the 1980 commissioners standard ordinary mortality table;

(B) at the election of the insurer for any one or more specified policies of life insurance, the 1980 commissioners standard ordinary mortality table with 10-year select mortality factors; or

(C) any ordinary mortality table adopted after 2001 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for policies;

(iii) for policies issued on or after January 1, 2005, and before January 1, 2009, at the election of the insurer for any one or more specified policies of life insurance, the 2001 commissioners standard ordinary mortality table; or

(iv) for policies issued prior to the operative date of the valuation manual but on or after January 1, 2009, the 2001 commissioners standard ordinary mortality table;

(b) for all industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in the policies, the 1941 standard industrial mortality table for policies issued prior to the operative date of 33-20-207 and, for policies issued on or after that operative date, the 1961 commissioners standard industrial mortality table or any industrial mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for the policies;

(c) for individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the 1937 standard annuity mortality table or, at the option of the insurer, the annuity mortality table for 1949, ultimate, or any modification of either of these tables approved by the commissioner;

(d) for group annuity and pure endowment contracts, excluding any disability and accidental death benefits in the policies, the group annuity mortality table for 1951, any modification of the table approved by the commissioner, or, at the option of the insurer, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(e) (i) for total and permanent disability benefits in or supplementary to ordinary policies or contracts:

(A) for policies or contracts issued on or after January 1, 1966, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit, or any tables of disablement rates and termination rates adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum standard of valuation for the policies;

(B) for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either the tables or, at the option of the insurer, the class 3 disability table (1926); and

(C) for policies issued prior to January 1, 1961, the class 3 disability table (1926);

(ii) any table must, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(f) (i) for accidental death benefits in or supplementary to policies:

(A) for policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for the policies;

(B) for policies issued on or after January 1, 1961, and prior to January 1, 1966, a table referenced in subsection (2)(f)(i)(A) or, at the option of the insurer, the intercompany double indemnity mortality table; and

(C) for policies issued prior to January 1, 1961, the intercompany double indemnity mortality table;

(ii) either table must be combined with a mortality table permitted for calculating the reserves for life insurance policies;

(g) for group life insurance, life insurance issued on the substandard basis, and other special benefits, the tables approved by the commissioner.

History: En. Sec. 92, Ch. 286, L. 1959; amd. Sec. 1, Ch. 61, L. 1961; amd. Sec. 1, Ch. 41, L. 1965; amd. Sec. 1, Ch. 341, L. 1973; R.C.M. 1947, 40-3011(part); amd. Sec. 1, Ch. 346, L. 1979; amd. Sec. 1, Ch. 520, L. 1983; amd. Sec. 14, Ch. 379, L. 1995; amd. Sec. 142, Ch. 42, L. 1997; amd. Sec. 4, Ch. 469, L. 2005; amd. Sec. 18, Ch. 370, L. 2015; Sec. 33-2-523, MCA 2013; redes. 33-2-409 by Sec. 40, Ch. 370, L. 2015.

33-2-410. Individual and group annuity and pure endowment contracts — valuation. (1) Except as provided in 33-2-413, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this section, as defined herein, and for all annuities and pure endowments purchased on or after that operative date under group annuity and pure endowment contracts is the commissioner's reserve valuation methods defined in 33-2-411 and the following tables and interest rates:

(a) for individual annuity and pure endowment contracts issued prior to July 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table or any modification of this table approved by the commissioner and 6% interest for single-premium immediate annuity contracts and 4% interest for all other individual annuity and pure endowment contracts;

(b) for individual single-premium immediate annuity contracts issued on or after July 1, 1979, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table or any individual annuity mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for such contracts or any modification of such tables approved by the commissioner and 7½% interest;

(c) for individual annuity and pure endowment contracts issued on or after July 1, 1979, other than single-premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table or any individual annuity mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for such contracts or any modification of such tables approved by the commissioner and 5½% interest for single-premium deferred annuity and pure endowment contracts and 4½% interest for all other such individual annuity and pure endowment contracts;

(d) for all annuities and pure endowments purchased prior to July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table or any modification of the table approved by the commissioner and 6% interest;

(e) for all annuities and pure endowments purchased on or after July 1, 1979, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table or any group annuity mortality table adopted after 1980 by the national association of insurance commissioners that is approved by the commissioner by rule for use in determining the minimum standard of valuation for such annuities and pure endowments or any modification of such tables approved by the commissioner and 7½% interest.

(2) After March 17, 1973, any insurer may file with the commissioner a written notice of its election to comply with the provisions of subsection (1) after a specified date before January 1, 1979, which shall be the operative date of subsection (1) for such insurer. An insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this section for such insurer shall be January 1, 1979.

History: En. Sec. 92, Ch. 286, L. 1959; amd. Sec. 1, Ch. 61, L. 1961; amd. Sec. 1, Ch. 41, L. 1965; amd. Sec. 1, Ch. 341, L. 1973; R.C.M. 1947, 40-3011(part); amd. Sec. 9, Ch. 198, L. 1979; amd. Sec. 2, Ch. 346, L. 1979; amd. Sec. 2, Ch. 520, L. 1983; Sec. 33-2-524, MCA 2013; redes. 33-2-410 by Sec. 40, Ch. 370, L. 2015.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-2-411. Commissioner's reserve valuation method. (1) Except as otherwise provided in 33-2-412(3) and (4), 33-2-417(2), and subsection (4) of this section, reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, must be the excess, if any, of the present value, at the date of valuation, of future guaranteed benefits provided for by the policies, over the then present value of any future modified net premiums. The modified net premiums for any policy must be the uniform percentage of the respective contract premiums for the benefits that the present value, at the date of issue of the policy, of all modified net premiums must be equal to the sum of the then present value of the benefits provided for by the policy and the excess of subsection (1)(a) over subsection (1)(b), as follows:

(a) a net level annual premium equal to the present value, at the date of issue, of benefits provided for after the first policy year, divided by the present value, at the date of issue of an annuity of one per annum payable on the first and each subsequent anniversary of the policy on which a premium falls due. However, the net level annual premium may not exceed the net level annual premium on the 19-year premium whole life plan for insurance of the same amount at an age 1 year higher than the age at issue of the policy.

(b) a net 1-year term premium for benefits provided for in the first policy year.

(2) (a) For each life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year, for which a comparable additional benefit is not provided in the first year for the excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than the excess premium, the reserve according to the commissioner's reserve valuation method, as of any policy anniversary occurring on or before the assumed ending date as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than the excess premium, is, except as otherwise provided in 33-2-412, the greater of the reserve as of the policy anniversary calculated as described in subsection (1) or the reserve as of the policy anniversary calculated as described in subsection (1) with the following exceptions:

(i) the value defined in subsection (1)(a) is reduced by 15% of the amount of the excess first-year premium;

(ii) all present values of benefits and premiums are determined without reference to premiums or benefits provided for in the policy after the assumed ending date;

(iii) the policy is assumed to mature on the assumed ending date as an endowment; and

(iv) the cash surrender value provided on the assumed ending date is considered an endowment benefit.

(b) In making the comparisons in subsection (2)(a), the mortality and interest bases stated in 33-2-409 and 33-2-413 must be used.

(3) Reserves according to the commissioner's reserve valuation method for the following must be calculated by a method consistent with the principles of this section, except that any extra premiums charged because of impairments or special hazards must be disregarded in the determination of modified net premiums:

(a) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as amended;

(c) disability and accidental death benefits in all policies and contracts; and

(d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts.

(4) (a) Subsection (4)(b) applies to any annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as amended.

(b) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in the contracts, must be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by the contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations required by the terms of the contract that become payable prior to the end of the respective contract year. The future guaranteed benefits must be determined by using the mortality table, if any, and the interest rate or rates specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of the contracts to determine nonforfeiture values.

(c) The commissioner's reserve valuation method provided by this section is subject to the provisions of the valuation manual as adopted by the commissioner.

History: En. Sec. 92, Ch. 286, L. 1959; amd. Sec. 1, Ch. 61, L. 1961; amd. Sec. 1, Ch. 41, L. 1965; amd. Sec. 1, Ch. 341, L. 1973; R.C.M. 1947, 40-3011(part); amd. Sec. 3, Ch. 346, L. 1979; amd. Sec. 6, Ch. 520, L. 1983; amd. Sec. 15, Ch. 379, L. 1995; amd. Sec. 19, Ch. 370, L. 2015; Sec. 33-2-525, MCA 2013; redes. 33-2-411 by Sec. 40, Ch. 370, L. 2015.

33-2-412. Limits — options — minimum reserves. (1) (a) An insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits issued on or after October 1, 1995, and prior to adoption of the valuation manual by the commissioner by rule may not be less than the aggregate reserves calculated in accordance with the methods set forth in 33-2-411, 33-2-417(2), subsection (3) of this section, and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for the policies.

(b) After the operative date of the valuation manual, the reserve valuation methods determined by the commissioner under 33-2-411(4)(c) must be used in conjunction with the provisions of this section.

(2) Reserves for all policies and contracts issued prior to October 1, 1995, may be calculated, at the option of the insurer, according to standards that produce greater aggregate reserves for those policies and contracts than the minimum reserves required by the laws in effect immediately prior to October 1, 1995. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after October 1, 1995, may be calculated at the option of the insurer according to any standards which produce greater aggregate reserves for a category than those calculated according to the minimum standard provided in this section, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for a category.

(3) If in any contract year the gross premium charged by any life insurer on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve on the policy or contract but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for the policy or contract must be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for the policy or contract or the reserve calculated by the method actually used for the policy or contract but using the minimum standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in 33-2-410 and 33-2-413.

(4) For every life insurance policy issued after December 30, 1986, for which the gross premium in the first policy year exceeds that of the second year, for which a comparable additional benefit is not provided in the first year for an excess, and that provides an endowment benefit, a cash surrender value, or a combination of both in an amount greater than the excess premium, subsections (1) through (3) of this section must be applied as if the method actually used in calculating the reserve for the policy were the method described in 33-2-411(1). The minimum reserve at each policy anniversary of the policy must be the greater of the minimum reserve calculated in accordance with 33-2-411 and the minimum reserve calculated in accordance with this section.

History: En. Sec. 92, Ch. 286, L. 1959; amd. Sec. 1, Ch. 61, L. 1961; amd. Sec. 1, Ch. 41, L. 1965; amd. Sec. 1, Ch. 341, L. 1973; R.C.M. 1947, 40-3011(part); amd. Sec. 4, Ch. 346, L. 1979; amd. Sec. 7, Ch. 520, L. 1983; amd. Sec. 16, Ch. 379, L. 1995; amd. Sec. 20, Ch. 370, L. 2015; Sec. 33-2-526, MCA 2013; redes. 33-2-412 by Sec. 40, Ch. 370, L. 2015.

33-2-413. Interest rates — determination of minimum standard valuation. (1) For policies issued prior to the operative date of the valuation manual, the calendar year statutory valuation interest rates as established in this section must be used in determining the minimum standard for the valuation of:

(a) all life insurance policies issued in a particular calendar year on or after January 1, 1989;

(b) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984;

(c) all annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984, under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, 1984, in amounts held under guaranteed interest contracts.

(2) Except as provided in subsection (3), the calendar year statutory valuation interest rates are determined as follows and the results rounded to the nearer 1/4 of 1%, when R_1 is the lesser of R and .09, R_2 is the greater of R and .09, R is the reference interest rate established in 33-2-415, and W is the weighting factor established in 33-2-414:

(a) for life insurance:

$\text{Interest rate} = .03 + W(R_1 - .03) + (W/2)(R_2 - .09)$;

(b) for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$\text{Interest rate} = .03 + W(R - .03)$;

(c) for other annuities with:

(i) cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subsection (2)(b), the formula for life insurance stated in subsection (2)(a) applies to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years and the formula for single-premium immediate annuities stated in subsection (2)(b) applies to annuities and guaranteed interest contracts with guarantee durations of 10 years or less;

(ii) no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single-premium immediate annuities stated in subsection (2)(b) applies; and

(iii) cash settlement options and guaranteed interest contracts with cash settlement options valued on a change-in-fund basis, the formula for single-premium immediate annuities stated in subsection (2)(b) applies.

(3) If the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than 1/2 of 1%, the calendar year statutory valuation interest rate for such life insurance policies is equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of this subsection, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year must be determined for 1980 (using the reference interest rate defined for 1979) and must be determined for each subsequent calendar year regardless of when 33-20-208 becomes operative.

History: En. Sec. 3, Ch. 520, L. 1983; amd. Sec. 21, Ch. 370, L. 2015; Sec. 33-2-527, MCA 2013; redes. 33-2-413 by Sec. 40, Ch. 370, L. 2015.

33-2-414. Interest rate weighting factor. (1) The weighting factors referred to in the formulas stated in 33-2-413 are as follows:

(a) (i) for life insurance:

Guarantee Duration in Years	Weighting Factors
10 or less	.50
More than 10 but not more than 20	.45
More than 20	.35

(ii) for life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values, or both, that are guaranteed in the original policy;

(b) .80 for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options;

(c) for other annuities and for guaranteed interest contracts, except as stated in subsection (1)(b), according to the guarantee duration established in subsections (1)(c)(i) through (1)(c)(iii) and the rules and definitions established in subsections (2) through (4):

(i) for annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration in Years	Weighting Factor for Plan Type		
	A	B	C
5 or less	.80	.60	.50
More than 5 but not more than 10	.75	.60	.50
More than 10 but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

	Plan Type		
(ii)	A	B	C
for annuities and guaranteed interest contracts valued on a change-in-fund basis, the factors shown in subsection (1)(c)(i) increased by:	.15	.25	.05

	Plan Type		
	A	B	C
(iii) for annuities and guaranteed interest contracts valued on an issue year basis, other than those without cash settlement options, that do not guarantee interest on considerations received more than 1 year after issue or purchase and for annuities and guaranteed interest contracts valued on a change-in-fund basis that do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors set forth in subsection (1)(c)(i) or derived in subsection (1)(c)(ii) increased by:	.05	.05	.05

(2) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities without cash settlement options and for guaranteed interest contracts without cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(3) Plan types used in subsection (1)(c) are:

(a) Plan Type A—No withdrawal is permitted or at any time policyholder may withdraw funds only:

(i) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(ii) without an adjustment but in installments over 5 years or more; or

(iii) as an immediate life annuity.

(b) Plan Type B—

(i) Before expiration of the interest rate guarantee, no withdrawal is permitted or a policyholder may withdraw funds only:

(A) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(B) without an adjustment but in installments over 5 years or more.

(ii) At the end of the interest rate guarantee, funds may be withdrawn without an adjustment in a single sum or installments over less than 5 years.

(c) Plan Type C—A policyholder may withdraw funds before expiration of the interest rate guarantee in a single sum or installments over less than 5 years either:

(i) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or

(ii) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(4) (a) An insurer may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change-in-fund basis. Guaranteed interest contracts without cash settlement options and other annuities without cash settlement options must be valued on an issue year basis.

(b) As used in subsection (4):

(i) issue year basis of valuation is a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract; and

(ii) change-in-fund basis of valuation is a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

History: En. Sec. 4, Ch. 520, L. 1983; amd. Sec. 17, Ch. 379, L. 1995; Sec. 33-2-528, MCA 2013; redes. 33-2-414 by Sec. 40, Ch. 370, L. 2015.

33-2-415. Reference interest rate. (1) The reference interest rate referred to in the formulas in 33-2-413 is:

(a) for all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of Moody's monthly average composite yield on seasoned corporate bonds;

(b) for single-premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's monthly average composite yield on seasoned corporate bonds;

(c) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's monthly average composite yield on seasoned corporate bonds;

(d) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a year-of-issue basis, except as stated in subsection (1)(b), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's monthly average composite yield on seasoned corporate bonds;

(e) for other annuities without cash settlement options and for guaranteed interest contracts without cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of Moody's monthly average composite yield on seasoned corporate bonds; or

(f) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options valued on a change-in-fund basis, except as stated in subsection (1)(b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of Moody's monthly average composite yield on seasoned corporate bonds.

(2) If Moody's monthly average composite yield on seasoned corporate bonds is no longer published by Moody's investors service, inc., or if the national association of insurance commissioners determines that Moody's monthly average composite yield on seasoned corporate bonds, as published by Moody's investors service, inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate adopted by the national association of insurance commissioners and approved by rule promulgated by the commissioner may be substituted.

History: En. Sec. 5, Ch. 520, L. 1983; amd. Sec. 18, Ch. 379, L. 1995; Sec. 33-2-529, MCA 2013; redes. 33-2-415 by Sec. 40, Ch. 370, L. 2015.

33-2-416. Deposit of reserves — domestic life insurers. (1) Domestic life insurers shall deposit and maintain on deposit, in securities and assets, with depositaries and subject to conditions as provided for in part 6 of this chapter, an amount not less than the reserves on its outstanding life insurance policies and annuity contracts, as valued under 33-2-407 through 33-2-412, minus policy loans.

(2) Annually on or before April 1, the insurer shall deposit any additional securities or assets required under subsection (1) and related to the increase of the reserves, minus policy loans, during the preceding calendar year, as determined from the insurer's annual statement as at December 31 of the preceding year.

(3) A domestic stock life insurer may credit toward the deposit the amount of any other deposit of the insurer held under part 6 of this chapter for the protection of its policyholders or of its policyholders and creditors.

(4) Deposits of the reserves of a domestic life insurer under this section must consist of securities and assets acquired and valued in accordance with chapter 12 and part 5 of this chapter.

(5) Real estate mortgage loans and chattel mortgage loans may be made a part of the deposit by filing a verified statement of the loans with the commissioner. The statement is subject to audit at all times by the commissioner. Nonnegotiable securities deposited with the commissioner must be accompanied by transfer powers in due form. If the insurer uses

real estate acquired under 33-12-207 as a deposit, then a deed of trust, mortgage, or other instrument sufficient to convey a security interest in the real estate, in a form acceptable to the commissioner, must be completed in due form and recorded prior to being deposited with the commissioner.

(6) If default occurs in the payment of interest or principal of any deposited security and the default continues for a period of 120 days, the commissioner may declare the security no longer eligible for deposit under this section.

History: En. Sec. 93, Ch. 286, L. 1959; R.C.M. 1947, 40-3012; amd. Sec; 2, Ch. 570, L. 1979; amd. Sec. 1, Ch. 427, L. 1981; amd. Sec. 19, Ch. 379, L. 1995; amd. Sec. 40, Ch. 304, L. 1999; Sec. 33-2-531, MCA 2013; redes. 33-2-416 by Sec. 40, Ch. 370, L. 2015.

Cross-References

Deposit requirement, 33-2-111.
Deposits — general provisions, Title 33, ch. 2, part 6.
Duration and release of deposit, 33-2-612.
Mortgages of real property, Title 71, ch. 1, part 2.
Deeds of trust, Title 71, ch. 1, part 3.

33-2-417. Reserve calculation — indeterminate premium plans — minimum standards for disability plans and accident and health plans. (1) In the case of a plan of life insurance that provides for future premium determination, the amounts of which are to be determined by the insurer based on then estimates of future experience, or in the case of a plan of life insurance or annuity that is of a nature that the minimum reserves cannot be determined by the methods described in 33-2-411 and 33-2-412(3), the reserves that are held under the plan must:

(a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) be computed by a method that is consistent with the principles of 33-2-407 through 33-2-415.

(2) The commissioner may promulgate a rule containing the minimum standards applicable to the valuation of disability plans issued prior to the operative date of the valuation manual. For accident and health insurance contracts issued on or after the operative date of the valuation manual and after the applicable effective date provided in 33-2-403, the minimum standard of valuation prescribed by the valuation manual must be used.

History: En. Sec. 76, Ch. 379, L. 1995; amd. Sec. 7, Ch. 531, L. 1997; amd. Sec. 22, Ch. 370, L. 2015; Sec. 33-2-537, MCA 2013; redes. 33-2-417 by Sec. 40, Ch. 370, L. 2015.

33-2-418. Rulemaking. The commissioner shall adopt rules necessary to implement the provisions of this part, including but not limited to adopting the valuation manual.

History: En. Sec. 16, Ch. 370, L. 2015.

Part 5
Assets and Liabilities — Reserves

33-2-501. Assets allowed. In any determination of the financial condition of an insurer, there must be allowed as assets only assets that are owned by the insurer and that consist of:

(1) cash in the possession of the insurer or in transit under its control and including the true balance of any deposit in a solvent bank or trust company;

(2) investments, securities, properties, and loans acquired or held in accordance with this code and in connection therewith the following items:

(a) interest due or accrued on any bond or evidence of indebtedness which is not in default and which is not valued on a basis including accrued interest;

(b) declared and unpaid dividends on stock and shares unless the amount has otherwise been allowed as an asset;

(c) interest due or accrued upon a collateral loan in an amount not to exceed 1 year's interest on the loan;

(d) interest due or accrued on deposits in solvent banks and trust companies and interest due or accrued on other assets, if the interest is in the judgment of the commissioner a collectible asset;

(e) interest due or accrued on a mortgage loan in an amount not exceeding in any event the amount, if any, of the excess of the value of the property less delinquent taxes on the property over the unpaid principal. Interest accrued for a period in excess of 18 months may not be allowed as an asset.

(f) rent due or accrued on real property if the rent is not in arrears for more than 3 months and rent more than 3 months in arrears if the payment of the rent is adequately secured by property held in the name of the tenant and conveyed to the insurer as collateral;

(g) the unaccrued portion of taxes paid prior to the due date on real property;

(3) premium notes, policy loans, and other policy assets and liens on policies and certificates of life insurance and annuity contracts and accrued interest, in an amount not exceeding the legal reserve and other policy liabilities carried on each individual policy;

(4) the net amount of uncollected and deferred premiums and annuity considerations in the case of a life insurer;

(5) premiums in the course of collection, other than for life insurance, not more than 3 months past due, less commissions payable on the premiums. The limitation in this subsection does not apply to premiums payable directly or indirectly by the United States government or by any of its instrumentalities.

(6) installment premiums other than life insurance premiums to the extent of the unearned premium reserve carried on the policy to which premiums apply;

(7) notes and like written obligations not past due, taken for premiums other than life insurance premiums, on policies permitted to be issued on that basis, to the extent of the unearned premium reserves carried on the policies;

(8) the full amount of reinsurance recoverable by a ceding insurer from a solvent reinsurer and which reinsurance is authorized under chapter 2, part 12;

(9) amounts receivable by an assuming insurer representing funds withheld by a solvent ceding insurer under a reinsurance treaty;

(10) deposits or equities recoverable from underwriting associations, syndicates, and reinsurance funds or from any suspended banking institution, to the extent considered by the commissioner available for the payment of losses and claims and at values to be determined by the commissioner;

(11) electronic data processing equipment if the cost of the equipment is amortized in full over a period of not to exceed 8 calendar years. However, the amount of the asset allowed may not exceed 1% of the total of the other allowable assets of the insurer.

(12) all assets, whether or not consistent with the provisions of this section, as may be allowed pursuant to the annual statement form approved by the commissioner for the kinds of insurance to be reported upon in the annual statement;

(13) other assets, not inconsistent with the provisions of this section, considered by the commissioner to be available for the payment of losses and claims, at values to be determined by the commissioner.

History: En. Sec. 82, Ch. 286, L. 1959; R.C.M. 1947, 40-3001; amd. Sec. 1, Ch. 570, L. 1979; amd. Sec. 40, Ch. 596, L. 1993; amd. Sec. 12, Ch. 379, L. 1995.

Cross-References

Net premium tax — admitted assets, 33-2-705.

Montana Facility Finance Authority bonds — legal investment, 90-7-113.

33-2-502. Assets expressly not allowed. In addition to assets impliedly excluded by the provisions of 33-2-501, the following expressly may not be allowed as assets in any determination of the financial condition of an insurer:

(1) goodwill, trade names, and other like intangible assets;

(2) advances to officers, other than policy loans, whether secured or not, and advances to employees, insurance producers, and other persons on personal security only;

(3) stock issued and owned by the insurer, any equity in the stock issued by the insurer, loans secured by the stock issued by the insurer, or any proportionate interest in the stock acquired or held through the ownership by the insurer of an interest in another firm, corporation, or business unit;

(4) furniture, fixtures (other than electronic data processing machines authorized under 33-2-501(11)), furnishings, safes, vehicles, libraries, stationery, literature, and supplies, except:

(a) in the case of title insurers, materials and plants that the insurer is expressly authorized to invest in under 33-25-211; and

(b) in the case of any insurer, personal property that the insurer is permitted to hold pursuant to chapter 12, that is acquired through foreclosure of chattel mortgages acquired pursuant to 33-12-207 or 33-12-307, or that is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch office, and similar purposes;

(5) the amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value of the investments as determined under this title; and

(6) prepaid expenses.

History: En. Sec. 84, Ch. 286, L. 1959; R.C.M. 1947, 40-3003; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 39, Ch. 304, L. 1999; amd. Sec. 13, Ch. 472, L. 1999.

33-2-503. Treatment of assets. Assets may be allowed as deductions from corresponding liabilities, liabilities may be charged as deductions from assets, and deductions from assets may be charged as liabilities, in accordance with the form of annual statement applicable to the insurer as prescribed by the commissioner.

History: En. Sec. 83, Ch. 286, L. 1959; R.C.M. 1947, 40-3002; amd. Sec. 1085, Ch. 56, L. 2009.

33-2-504 through 33-2-510 reserved.

33-2-511. Liabilities chargeable against assets. In any determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include:

(1) the amount of its capital stock outstanding, if any;

(2) the amount, estimated consistent with the provisions of this code, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement thereof;

(3) with reference to life and disability insurance and annuity contracts:

(a) the amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted pursuant to this code which are applicable thereto;

(b) reserves for disability benefits, for both active and disabled lives;

(c) reserves for accidental death benefits;

(d) any additional reserves which may be required by the commissioner, consistent with practice formulated or approved by the national association of insurance commissioners, on account of such insurance;

(4) with reference to insurance other than specified in subsection (3) of this section and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this part;

(5) taxes, expenses, and other obligations due or accrued at the date of the statement.

History: En. Sec. 85, Ch. 286, L. 1959; R.C.M. 1947, 40-3004.

33-2-512. Unearned premium reserve for property, casualty, and surety. (1) As to insurance against loss or damage to property, except as provided in 33-2-513, and as to all general casualty insurance and surety insurance, every insurer shall maintain an unearned premium reserve on all policies in force.

(2) The commissioner may require that such reserves shall be equal to the unearned portions of the gross premiums in force after deducting applicable reinsurance in solvent insurers as computed on each respective risk from the policy's date of issue. If the commissioner does not so require, the portions of the gross premium in force, less applicable reinsurance in solvent insurers, to be held as an unearned premium reserve, shall be computed according to the following table:

Term for Which Policy Was Written	Reserve for Unearned Premium
1 year or less	1/2
2 years	1st year 3/4
	2nd year 1/4
3 years	1st year 5/6
	2nd year 1/2

	3rd year	1/6
4 years	1st year	7/8
	2nd year	5/8
	3rd year	3/8
	4th year	1/8
5 years	1st year	9/10
	2nd year	7/10
	3rd year	1/2
	4th year	3/10
	5th year	1/10
Over 5 years	pro rata	

(3) In lieu of computation according to the foregoing table, the insurer at its option may compute all of such reserves on a monthly or more frequent pro rata basis.

(4) After adopting a method for computing such reserve, an insurer shall not change methods without approval of the commissioner.

(5) This section does not apply to title insurance.

History: En. Sec. 86, Ch. 286, L. 1959; R.C.M. 1947, 40-3005.

Cross-References

Title insurance reserves, 33-2-517.

33-2-513. Unearned premium reserve for marine and transportation insurance. As to marine and transportation insurance, the entire amount of premiums on trip risks not terminated shall be deemed unearned and the commissioner may require the insurer to carry a reserve equal to 100% of premiums on trip risks written during the month ended as of the date of statement.

History: En. Sec. 87, Ch. 286, L. 1959; R.C.M. 1947, 40-3006.

33-2-514. Reserve for disability insurance. (1) For all disability insurance policies, the insurer shall maintain an active life reserve that places a sound value on its liabilities under the policies and that may not be less than the pro rata gross unearned premiums for the policies.

(2) The commissioner may promulgate rules to define additional standards for reserve requirements.

History: En. Sec. 88, Ch. 286, L. 1959; R.C.M. 1947, 40-3007; amd. Sec. 5, Ch. 531, L. 1997.

33-2-515. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 89, Ch. 286, L. 1959; R.C.M. 1947, 40-3008.

33-2-516. Inadequate reserves — increase required. If loss experience shows that an insurer's loss reserves, however computed or estimated, are inadequate, the commissioner shall require the insurer to maintain loss reserves in such increased amount as is needed to make them adequate.

History: En. Sec. 90, Ch. 286, L. 1959; R.C.M. 1947, 40-3009.

33-2-517. Title insurance reserves. (1) In addition to an adequate reserve as to outstanding losses as required under 33-2-511, a title insurer shall maintain a guaranty fund or unearned premium reserve of not less than an amount computed as follows:

(a) Ten percent of the total amount of the risk premiums written in the calendar year for title insurance contracts must be assigned originally to the reserve.

(b) During each of the 20 years next following the year in which the title insurance contract was issued, the reserve applicable to the contract must be reduced by 5% of the original amount of the reserve.

(2) The reserve sums required by subsection (1) for unearned premiums on contracts of title insurance must at all times and for all purposes be considered and constitute unearned portions of the original premiums and must be held in trust for the benefit of policyholders.

(3) The reduction of the unearned premium reserve required by subsection (1)(b) must be made for all title insurance contracts issued after December 31, 1958, with respect to which 10% of the risk premiums have been assigned to the reserve pursuant to subsection (1)(a). If the

insurer has not reduced the amount of its unearned premium reserves pursuant to subsection (1)(b) for a previous year or years, the insurer shall make the reduction for the prior year or years in its next accounting year.

History: **En. Sec. 91, Ch. 286, L. 1959; amd. Sec. 1, Ch. 96, L. 1977; R.C.M. 1947, 40-3010; amd. Sec. 6, Ch. 531, L. 1997.**

Cross-References

Title insurance — general provisions, Title 33, ch. 25.

33-2-518. Loss and loss expense reserves for property and casualty insurance. (1) (a) In determining the financial condition of a property and casualty insurer for the purpose of applying the provisions of this chapter and in any financial statement or report of an insurer, loss reserves and loss expense reserves at least equal to the amounts required under the provisions of this section must be included in the insurer's liabilities. The date from which the determination, statement, or report is made is, for the purpose of this part, the date of determination.

(b) Accepted actuarial standards as adopted by the actuarial standards board must be taken into consideration for the purpose of determining the loss reserves and loss expense reserves.

(2) Except as provided in subsections (3) and (4), the reserves for all outstanding losses and loss expenses must include the following:

(a) the aggregate estimated amounts due or to become due on account of all known losses, claims, and loss expenses incurred but not paid, including the estimated liability on any notice received by the insurer of the occurrence of any event that may result in a loss; and

(b) the aggregate amounts of liability for all losses and loss expenses incurred for which notice has not been received, estimated in accordance with the insurer's prior experience, if any, or otherwise in accordance with Montana industry experience, or countrywide industry experience if this state's experience is not credible, for similar contracts of insurance. The estimated liabilities for losses under all bonds, policies, or contracts of fidelity insurance may not be less than 10% of the net premiums in force, and the estimated liabilities for all of those losses under all the insurer's surety contracts may not be less than 5% of the net premiums in force.

(3) Except as provided in subsection (4), tabular reserves for outstanding losses under policies of workers' compensation insurance may be actuarially calculated for both indemnity and medical payments. The loss adjustment expenses are not eligible for discounting. Tabular reserves are those reserves that are:

(a) calculated using discounts determined with reference to actuarial tables, which incorporate mortality, interest, not to exceed 4%, remarriage, and other contingencies applied to a reasonably determinable payment stream associated with lifetime benefit cases; or

(b) annuities certain, such as those arising from structured settlements.

(4) Whenever, in the judgment of the commissioner, the loss and loss expense reserves of any property and casualty insurer doing business in this state, calculated in accordance with the provisions of this section, are inadequate or excessive, the commissioner may prescribe any other method that will produce adequate and reasonable reserves.

(5) The excess, if any, of statutory reserves over statement reserves must be calculated in accordance with the annual statement instructions adopted by the national association of insurance commissioners.

History: **En. Sec. 43, Ch. 531, L. 1997.**

33-2-519 and 3-2-520 reserved.

33-2-521. Renumbered 33-2-407. Sec. 40, Ch. 370, L. 2015.

33-2-522. Renumbered 33-2-408. Sec. 40, Ch. 370, L. 2015.

33-2-523. Renumbered 33-2-409. Sec. 40, Ch. 370, L. 2015.

33-2-524. Renumbered 33-2-410. Sec. 40, Ch. 370, L. 2015.

33-2-525. Renumbered 33-2-411. Sec. 40, Ch. 370, L. 2015.

33-2-526. Renumbered 33-2-412. Sec. 40, Ch. 370, L. 2015.

33-2-527. Renumbered 33-2-413. Sec. 40, Ch. 370, L. 2015.

33-2-528. Renumbered 33-2-414. Sec. 40, Ch. 370, L. 2015.

33-2-529. Renumbered 33-2-415. Sec. 40, Ch. 370, L. 2015.

33-2-530 reserved.

33-2-531. Renumbered 33-2-416. Sec. 40, Ch. 370, L. 2015.

33-2-532. Repealed. Sec. 40, Ch. 469, L. 2005.

History: En. Sec. 94, Ch. 286, L. 1959; R.C.M. 1947, 40-3013; amd. Sec. 41, Ch. 596, L. 1993.

33-2-533. Repealed. Sec. 40, Ch. 469, L. 2005.

History: En. Sec. 95, Ch. 286, L. 1959; R.C.M. 1947, 40-3014; amd. Sec. 42, Ch. 596, L. 1993.

33-2-534. Repealed. Sec. 40, Ch. 469, L. 2005.

History: En. Sec. 96, Ch. 286, L. 1959; R.C.M. 1947, 40-3015; amd. Sec. 2, Ch. 534, L. 1987; amd. Sec. 41, Ch. 304, L. 1999.

33-2-535. Repealed. Sec. 40, Ch. 469, L. 2005.

History: En. Sec. 97, Ch. 286, L. 1959; R.C.M. 1947, 40-3016.

33-2-536. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 8, Ch. 520, L. 1983.

33-2-537. Renumbered 33-2-417. Sec. 40, Ch. 370, L. 2015.

Part 6
Deposits

33-2-601. Authorized deposits of insurers. The following deposits of insurers when made through the commissioner must be accepted and held and are subject to the provisions of this part:

(1) deposits required under this code for authority to transact insurance in this state;

(2) deposits of domestic insurers when required by the laws of other states, provinces, and countries as a condition for the authority to transact insurance; or

(3) deposits of reserves made by domestic life insurers under 33-2-416.

History: En. Sec. 132, Ch. 286, L. 1959; R.C.M. 1947, 40-3201; amd. Sec. 7, Ch. 227, L. 2011.

Cross-References

Deposit requirement — general provision, 33-2-111.

33-2-602. Purpose of deposit. Such deposits shall be held for purposes as follows:

(1) Deposits made in this state under 33-2-111 shall be held for the purpose stated in such section.

(2) A deposit made in this state by a domestic insurer transacting insurance in another state, province, or country and as required by the laws of such other state, province, or country shall be held for the protection of all the insurer's policyholders or all its policyholders and creditors or for such other purpose or purposes as may be specified pursuant to such laws.

(3) Deposits of reserves made by domestic life insurers under 33-2-416 shall be held for the common benefit of all the holders of its life insurance policies and annuity contracts.

(4) Deposits required pursuant to the retaliatory law, 33-2-709, shall be held for such purposes as is required by such law and as specified by the commissioner's order requiring such deposit to be made.

History: En. Sec. 133, Ch. 286, L. 1959; R.C.M. 1947, 40-3202.

Cross-References

Alien insurers — deposit of trusteed assets, 33-2-202.

33-2-603. Securities eligible for deposit. (1) All deposits required under 33-2-111 for authority to transact insurance in this state must consist of certificates of deposit or the following securities:

(a) United States or Canadian government bonds, notes, warrants, or other evidences of indebtedness that are direct obligations of the United States or of Canada or for which the full faith and credit of the United States or of Canada is pledged for the payment of principal and interest;

(b) state, county, municipal, and school bonds or other evidences of indebtedness that are general obligations of or are secured by a pledge of specific revenue of a state or of a province of Canada or of any of the counties, incorporated cities or towns, school districts, or other taxing districts in a state or province; and

(c) revenue bonds, notes, or other evidences of indebtedness of any state or province, political subdivision of a state or province or agency or instrumentality of a state or province that are payable from revenue or earnings specifically pledged for the payment of the principal and interest on the obligations and for the payment of which a lawful sinking fund or reserve fund has been established and is being maintained.

(2) All other deposits of a domestic insurer held in this state pursuant to the laws of another state, province, or country must be comprised of assets of the kinds described in subsection (1) and of additional kind or kinds of securities required or permitted by the laws of the state, province, or country except common stocks, mortgages of any kind, and real estate.

(3) Deposits of the reserves of a domestic life insurer must consist of securities and assets as provided under 33-2-416.

(4) Deposits of foreign insurers made in this state under the retaliatory law, 33-2-709, must consist of assets that are required by the commissioner pursuant to 33-2-709.

History: En. Sec. 134, Ch. 286, L. 1959; R.C.M. 1947, 40-3203; amd. Sec. 42, Ch. 304, L. 1999.

33-2-604. Depositary or custodian. (1) Deposits made in this state under this code must be made through the office of the commissioner or under custodial arrangements as required or approved by the commissioner consistent with the purposes of the deposit. The deposit must be made with a bank or trust company located in the state of Montana and selected by the insurer with the commissioner's approval. The commissioner may, with good cause, withhold or withdraw approval.

(2) For convenience purposes, in the buying, selling, and exchange of securities comprising its deposit and in the collection of interest and other income currently accruing on the securities, the insurer may, with the commissioner's advance written approval, deposit the securities under custodial arrangements with an established bank or trust company located outside this state. Any receipts representing the securities that are issued by an out-of-state custodian bank or trust company are subject to the requirements of subsection (1).

(3) The form and terms of all depositary or custodial agreements must be as prescribed or approved by the commissioner, consistent with the applicable provisions of this code.

(4) The compensation and expenses of the depositary or custodian must be borne by the insurer.

History: En. Sec. 135, Ch. 286, L. 1959; R.C.M. 1947, 40-3204; amd. Sec. 3, Ch. 169, L. 2013.

Cross-References

Commercial bank defined, 32-1-105.
Savings bank defined, 32-1-106.
Trust company defined, 32-1-107.
Investment company defined, 32-1-108.

33-2-605. Record of deposits — liability of commissioner and state. (1) The commissioner shall give to the depositing insurer vouchers as to all assets and securities deposited by it in this state through the commissioner as provided in this code.

(2) The commissioner shall keep a record of the assets and securities comprising each deposit, showing as far as practical the amount and market value of each item, and all transactions relative to the deposits.

(3) The commissioner and the state of Montana do not have liability as to the safekeeping of any deposit by the depositary or custodian of the deposit.

History: (1), (2)En. Sec. 136, Ch. 286, L. 1959; Sec. 40-3205, R.C.M. 1947; (3)En. Sec. 137, Ch. 286, L. 1959; Sec. 40-3206, R.C.M. 1947; R.C.M. 1947, 40-3205, 40-3206; amd. Sec. 1086, Ch. 56, L. 2009.

33-2-606. Assignment or conveyance of assets or securities. All securities not negotiable by delivery and deposited under this code must be duly assigned to the commissioner. In the case of securities held under custodial arrangements outside this state pursuant to 33-2-604(2), the custodian's receipt for the securities must be delivered, if negotiable, or assigned to the commissioner if legal title to the securities is vested in the commissioner. The insurer shall transfer or convey to the commissioner all other assets deposited. Upon release to the insurer of any asset or security, the commissioner shall reassign or transfer or reconvey the asset or security to the insurer.

History: En. Sec. 138, Ch. 286, L. 1959; R.C.M. 1947, 40-3207; amd. Sec. 1087, Ch. 56, L. 2009; amd. Sec. 4, Ch. 169, L. 2013.

Cross-References

Security in real property — domestic life insurers — transferability requirements, 33-2-416.

33-2-607. Appraisal. The commissioner may, prior to acceptance for deposit of any particular asset or security or at any later time while deposited, have the asset or security appraised or valued by competent appraisers. The reasonable costs of any appraisal or valuation must be borne by the insurer.

History: En. Sec. 139, Ch. 286, L. 1959; R.C.M. 1947, 40-3208; amd. Sec. 1088, Ch. 56, L. 2009.

33-2-608. Rights of insurer during solvency. So long as the insurer remains solvent and is in compliance with this code it may:

(1) demand, receive, sue for, and recover the income from the assets or securities deposited;

(2) exchange and substitute for the deposited assets or securities, or any part thereof, other eligible assets or securities of equivalent or greater value; and

(3) at any reasonable time inspect any such deposit.

History: En. Sec. 140, Ch. 286, L. 1959; R.C.M. 1947, 40-3209.

Cross-References

Insolvency — supervision by Commissioner, 33-2-1321.

33-2-609. Repealed. Sec. 24, Ch. 227, L. 2011.

History: En. Sec. 141, Ch. 286, L. 1959; R.C.M. 1947, 40-3210.

33-2-610. Levy upon deposit. No judgment creditor or other claimant of an insurer shall have the right to levy upon any of the assets or securities held in this state as a deposit for the protection of the insurer's policyholders or policyholders and creditors. As to deposits pursuant to the retaliatory law, 33-2-709, levy thereupon shall be permitted if so provided in the commissioner's order under which the deposit is made.

History: En. Sec. 142, Ch. 286, L. 1959; R.C.M. 1947, 40-3211.

33-2-611. Deficiency of deposit — revocation of certificate. If for any reason the market value of assets and securities of an insurer held on deposit in this state or in another state under custodial arrangements authorized by 33-2-604(2) falls below the amount required under this code to be held, the insurer shall promptly deposit other or additional assets or securities eligible for deposit under this part and in an amount sufficient to cure the deficiency. If the insurer has failed to cure the deficiency within 20 days after receipt of notice of the deficiency by certified mail from the commissioner, the commissioner shall revoke the insurer's certificate of authority.

History: En. Sec. 143, Ch. 286, L. 1959; R.C.M. 1947, 40-3212; amd. Sec. 5, Ch. 169, L. 2013.

Cross-References

Revocation of certificate of authority, 33-2-118.

33-2-612. Duration and release of deposit. (1) Every deposit made in this state by an insurer pursuant to this code, including assets and securities held in another state under custodial arrangements permitted by 33-2-604(2), must be held as long as there is outstanding any liability of the insurer as to which the deposit was required, or if a deposit was required under the retaliatory law, 33-2-709, the deposit must be held for as long as the basis of the retaliation exists.

(2) Upon the request of a domestic insurer, the commissioner shall return to the insurer the whole or any portion of the assets and securities of the insurer held on deposit when the commissioner is satisfied that the assets and securities to be returned are not subject to liability and are not required to be held by any provision of law or purposes of the original deposit. If the insurer has reinsured all its outstanding risks in another insurer or insurers authorized to transact insurance in this state, then the commissioner shall deliver the assets and securities to the insurer or insurers assuming the risks upon:

(a) written notice to the commissioner by the domestic insurer that the assets and securities have been assigned, transferred, and set over to the reinsuring insurer or insurers, accompanied by a verified copy of the assignment, transfer, or conveyance; and

(b) in the case of deposits of the reserves of domestic life insurers under 33-2-416, proof satisfactory to the commissioner that the reinsuring insurer or insurers have deposited or will deposit and will maintain on deposit in public custody through the insurance supervisory official of its state of domicile assets and securities of like quality in an amount not less than the reserves of the policies and contracts reinsured, in addition to any other deposit of the insurer required or permitted by law, and, unless the insurer is required to deposit and maintain on deposit all of its reserves, that the deposit of the reserves will be deposited and held on deposit for the special benefit and protection of the holders of the life insurance policies and annuity contracts reinsured.

(3) The commissioner shall return to a foreign insurer any deposit made in this state by the insurer when the insurer has ceased transacting insurance in this state or in the United States, and the insurer is not subject to any liability in this state on account of which the deposit was held.

(4) If the insurer is subject to delinquency proceedings, as defined in part 13 of this chapter, upon the order of a court of competent jurisdiction, the commissioner shall yield the assets and securities held on deposit to the receiver, conservator, rehabilitator, or liquidator of the insurer or to any other properly designated official or officials who succeed to the management and control of the insurer's assets.

(5) A release of deposited assets may not be made except upon application to and the written order of the commissioner. The commissioner does not have personal liability for release of any deposit or part of a deposit made in good faith.

History: En. Sec. 144, Ch. 286, L. 1959; R.C.M. 1947, 40-3213; amd. Sec. 141, Ch. 575, L. 1981; amd. Sec. 1089, Ch. 56, L. 2009; amd. Sec. 6, Ch. 169, L. 2013.

Cross-References

State subject to suit, Art. II, sec. 18, Mont. Const.; 2-9-102.
Immunization and indemnification of public officers, 2-9-305.

Part 7
Reports, Fees, and Taxes

Part Cross-References

Report of surplus line insurance producer, 33-2-310.

33-2-701. Annual statement — revocation or fine for failure to file — penalty for perjury. (1) Each authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement of the authorized insurer's financial condition, transactions, and affairs as of the preceding December 31. The statement must be:

(a) in the general form and context as is required or not disapproved by the commissioner, as is in current use for similar reports to states in general with respect to the type of insurer and kinds of insurance to be reported upon, and as supplemented for additional information required by the commissioner;

(b) completed in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual of the national association of insurance commissioners;

(c) accompanied by an actuarial opinion attesting to the adequacy of the insurer's reserves;

(d) verified by the oath of the insurer's president or vice president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation. The commissioner may waive the verification under oath.

(2) (a) Each domestic insurer shall file electronic versions of the domestic insurer's annual and quarterly financial statements with the national association of insurance commissioners. The date for submission of the annual statement electronic filing is March 1. The dates for the submission of the quarterly statement electronic filings are as follows:

(i) the first quarter filing is due May 15;
(ii) the second quarter filing is due August 15; and
(iii) the third quarter filing is due November 15.

(b) The commissioner may exempt insurers that operate only in Montana from these filing requirements.

(3) The statement of an alien insurer must relate only to its transactions and affairs in the United States unless the commissioner requires otherwise. If the commissioner requires

a statement as to an alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible. The statement must be verified by the insurer's United States manager or other authorized officer.

(4) The commissioner may refuse to accept the fee for renewal of the insurer's certificate of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer failing to file the insurer's annual statement when due or within an extension of time that the commissioner may grant.

(5) A director, officer, agent, or employee of a company who subscribes to, makes, or concurs in making or publishing an annual statement or any other statement required by law knowing that the statement contains any material statement that is false shall be punished by a fine of not more than $25,000 for each violation.

(6) The commissioner may impose a fine not to exceed $100 a day for each day after March 1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed a maximum of $1,000.

History: En. Sec. 65, Ch. 286, L. 1959; amd. Sec. 1, Ch. 27, L. 1967; R.C.M. 1947, 40-2820; amd. Sec. 3, Ch. 534, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 43, Ch. 596, L. 1993; amd. Sec. 20, Ch. 379, L. 1995; amd. Sec. 3, Ch. 316, L. 1999; amd. Sec. 15, Ch. 472, L. 1999; amd. Sec. 1, Ch. 206, L. 2005; amd. Sec. 5, Ch. 469, L. 2005.

Cross-References

Revocation or suspension of certificate of authority, 33-2-118, 33-2-119.

False swearing, 45-7-202.

33-2-702 and 33-2-703 reserved.

33-2-704. Insured lives reporting requirement. On or before March 1 of each year, each insurer providing disability insurance shall, on a form prescribed by the commissioner, report the number of Montana residents insured on February 1 under any policy of individual or group disability insurance, including excess of loss or stop-loss insurance policies covering disability insurance.

History: En. Sec. 11, Ch. 377, L. 1995; amd. Sec. 8, Ch. 531, L. 1997.

33-2-705. Report on premiums and other consideration — tax. (1) Each authorized insurer and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state shall file with the commissioner, on or before March 1 each year, a report in a form prescribed by the commissioner showing total direct premium income, including policy, membership, and other fees, premiums paid by application of dividends, refunds, savings, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance, whether designated as a premium or otherwise, received by a life insurer or written by an insurer other than a life insurer during the preceding calendar year on account of policies covering property, subjects, or risks located, resident, or to be performed in Montana, with proper proportionate allocation of premium as to property, subjects, or risks in Montana insured under policies or contracts covering property, subjects, or risks located or resident in more than one state, after deducting from the total direct premium income applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer, all policy dividends, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to the policies. As to title insurance, "premium" includes the total charge for the insurance. A deduction may not be made of the cash surrender values of policies. Considerations received on annuity contracts may not be included in total direct premium income and are not subject to tax.

(2) (a) Except as provided in subsections (2)(b) and (2)(c), coincident with the filing of the tax report referred to in subsection (1) and subject to 33-2-709, each insurer shall pay to the commissioner a tax on the net premiums computed at the rate of 2.75%.

(b) All casualty insurers issuing policies of legal professional liability insurance pursuant to 33-1-206 shall pay to the commissioner a tax on the net premiums derived from legal professional liability insurance computed at a rate of 0.75%.

(c) A dormant captive insurer that has a valid certificate of dormancy shall pay to the commissioner an annual dormancy tax of $1,000 as provided in 33-28-401.

(3) That portion of the tax paid under this section by an insurer on account of premiums received for fire insurance must be separately specified in the report required by the commissioner for apportionment as provided by law. When insurance against fire is included with insurance of property against other perils at an undivided premium, the insurer shall make a reasonable allocation from the entire premium to the fire portion of the coverage as must be stated in the report and as may be approved or accepted by the commissioner.

(4) With respect to authorized insurers, the premium tax provided by this section or the annual dormancy tax under 33-28-401 must be payment in full and in lieu of all other demands for any and all state, county, city, district, municipal, and school taxes, licenses, fees, and excises of whatever kind or character, excepting only those prescribed by this code, taxes on real and tangible personal property located in this state, and taxes payable under 50-3-109.

(5) The commissioner may suspend or revoke the certificate of authority of any insurer that fails to pay its taxes as required under this section.

(6) In addition to the penalty provided for in subsection (5), the commissioner may impose on an insurer who fails to pay the tax required under this section a fine of $100 plus interest on the delinquent amount at the annual interest rate of 12%.

(7) The commissioner may by rule provide a quarterly schedule for payment of portions of the premium tax under this section during the year in which tax liability is accrued.

History: En. Sec. 66, Ch. 286, L. 1959; amd. Sec. 1, Ch. 160, L. 1961; amd. Sec. 1, Ch. 78, L. 1963; amd. Sec. 1, Ch. 26, L. 1965; amd. Sec. 1, Ch. 71, L. 1967; amd. Sec. 1, Ch. 358, L. 1969; amd. Sec. 1, Ch. 237, L. 1971; R.C.M. 1947, 40-2821(part); amd. Sec. 1, Ch. 664, L. 1979; amd. Sec. 7, Ch. 303, L. 1981; amd. Sec. 12, Ch. 467, L. 1981; amd. Sec. 1, Ch. 295, L. 1983; amd. Sec. 3, Ch. 518, L. 1983; amd. Sec. 3, Ch. 622, L. 1987; amd. Sec. 2, Ch. 798, L. 1991; amd. Sec. 30, Ch. 15, Sp. L. July 1992; amd. Sec. 8, Ch. 451, L. 1993; amd. Sec. 21, Ch. 379, L. 1995; amd. Sec. 18, Ch. 537, L. 2005; amd. Sec. 1, Ch. 309, L. 2009; amd. Sec. 1, Ch. 377, L. 2015; amd. Sec. 2, Ch. 304, L. 2017.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

Not subject to corporate income tax, 15-31-101.

Allocation of certain casualty insurance tax — firefighters' pension and compensation, 19-13-604, 19-17-301, 19-18-512.

Fire departments — reports to Commissioner, 19-18-511.

Allocation of certain casualty insurance tax — municipal police officers' retirement system, 19-19-305.

Revocation of certificate of authority, 33-2-118, 33-2-119.

Tax on surplus lines, 33-2-311.

Not applicable to health service corporations, 33-30-203.

Tax on fire insurance premiums — state fire prevention and investigation program, 50-3-109.

33-2-706. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 202, Ch. 286, L. 1959; amd. Sec. 1, Ch. 147, L. 1977; R.C.M. 1947, 40-3427; amd. Sec. 26, Ch. 537, L. 1987; amd. Sec. 2, Ch. 713, L. 1989.

33-2-707. Preemption of taxing. The state of Montana hereby preempts the field of imposing excise, privilege, franchise, income, license, and similar taxes, licenses, and fees upon insurers and their general insurance producers and insurance producers as such and on the intangible property of insurers or such insurance producers. No county, city, municipality, district, school district, or other political subdivision or agency in Montana shall levy upon insurers, or upon their general insurance producers and insurance producers as such, any such tax, license, or fee additional to such as are levied by the legislature of Montana in this code.

History: En. Sec. 66, Ch. 286, L. 1959; amd. Sec. 1, Ch. 160, L. 1961; amd. Sec. 1, Ch. 78, L. 1963; amd. Sec. 1, Ch. 26, L. 1965; amd. Sec. 1, Ch. 71, L. 1967; amd. Sec. 1, Ch. 358, L. 1969; amd. Sec. 1, Ch. 237, L. 1971; R.C.M. 1947, 40-2821(6); amd. Sec. 1, Ch. 713, L. 1989.

Cross-References

No payment of corporate tax, 15-31-101.

33-2-708. Fees and licenses. (1) (a) Except as provided in subsection (5), the commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, $100;

(B) biennial renewal of license, $50;
(C) lapsed license reinstatement fee, $100;
(ii) resident insurance producer's license lapsed license reinstatement fee, $100;
(iii) surplus lines insurance producer's license:
(A) application for original license and for issuance of license, if issued, $50;
(B) biennial renewal of license, $100;
(C) lapsed license reinstatement fee, $200;
(iv) insurance adjuster's license:
(A) application for original license, including issuance of license, if issued, $50;
(B) biennial renewal of license, $100;
(C) lapsed license reinstatement fee, $200;
(v) insurance consultant's license:
(A) application for original license, including issuance of license, if issued, $50;
(B) biennial renewal of license, $100;
(C) lapsed license reinstatement fee, $200;
(vi) viatical settlement broker's license:
(A) application for original license, including issuance of license, if issued, $50;
(B) biennial renewal of license, $100;
(C) lapsed license reinstatement fee, $200;
(vii) resident and nonresident rental car entity producer's license:
(A) application for original license, including issuance of license, if issued, $100;
(B) quarterly filing fee, $25;
(viii) an original notification fee for a life insurance producer acting as a viatical settlement broker, in accordance with 33-20-1303(2)(b), $50;
(ix) navigator certification:
(A) application for original certification, including issuance of certificate if issued, $100;
(B) biennial renewal of certification, $50;
(C) lapsed certification reinstatement fee, $100;
(x) 50 cents for each page for copies of documents on file in the commissioner's office.

(c) The commissioner may adopt rules to determine the date by which a nonresident insurance producer, a surplus lines insurance producer, an insurance adjuster, an insurance public adjuster, or an insurance consultant is required to pay the fee for the biennial renewal of a license.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) (a) Except as provided in subsection (3)(b), the commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, 33-28-201, and 50-3-109.

(b) The commissioner shall deposit 33% of the money collected under 33-2-705 in the special revenue account provided for in 53-4-1115.

(c) All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

(4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded.

(5) The commissioner shall collect a licensing fee of $500 for casualty insurance companies issuing policies of legal professional liability insurance pursuant to 33-1-206.

History: En. Sec. 45, Ch. 286, L. 1959; amd. Sec. 1, Ch. 32, L. 1969; amd. Sec. 1, Ch. 334, L. 1973; amd. Sec. 1, Ch. 444, L. 1975; amd. Sec. 1, Ch. 322, L. 1977; R.C.M. 1947, 40-2726(1), (2); amd. Sec. 10, Ch. 198, L. 1979; amd. Sec. 1, Ch. 344, L. 1979; amd. Sec. 8, Ch. 303, L. 1981; amd. Sec. 1, Ch. 391, L. 1985; amd. Sec. 15, Ch. 249, L. 1987; amd. Sec. 1, Ch. 469, L. 1987; amd. Sec. 27, Ch. 537, L. 1987; amd. Sec. 6, Ch. 351, L. 1989; amd. Sec. 5, Ch. 509, L. 1989; amd. Sec. 14, Ch. 713, L. 1989; amd. Sec. 3, Ch. 798, L. 1991; amd. Sec. 9, Ch. 451, L. 1993; amd. Sec. 44, Ch. 596, L. 1993; amd. Sec. 7, Ch. 622, L. 1993; amd. Sec. 1, Ch. 6, Sp. L. November 1993; amd. Sec. 1, Ch. 98, L. 1995; amd. Sec. 22, Ch. 379, L. 1995; amd. Sec. 1, Ch. 70, L. 1997; amd. Sec. 4, Ch. 316, L. 1999; amd. Sec. 25, Ch. 227, L. 2001; amd. Sec. 17, Ch. 298, L. 2001; amd. Sec. 12, Ch. 380, L. 2003; amd. Secs. 7, 25, Ch. 427,

L. 2003; amd. Sec. 1, Ch. 552, L. 2005; amd. Sec. 10, I.M. No. 155, approved Nov. 4, 2008; amd. Sec. 15, Ch. 486, L. 2009; amd. Sec. 1, Ch. 245, L. 2013; amd. Sec. 8, Ch. 63, L. 2015; amd. Sec. 2, Ch. 139, L. 2015; amd. Sec. 2, Ch. 377, L. 2015; amd. Sec. 14, Ch. 6, Sp. L. November 2017.

Cross-References

Fund structure, Title 17, ch. 2.

33-2-709. Retaliatory fees, taxes, and other obligations. (1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees, in the aggregate, and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Montana insurers or upon the insurance producers or representatives of such insurers which are in excess of such taxes, licenses, and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the insurance producers or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the commissioner upon the insurers or upon the insurance producers or representatives of such insurers of such other state or country doing business or seeking to do business in Montana. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Montana insurers or their insurance producers or representatives shall be deemed to be imposed by such state or country within the meaning of this section.

(2) This section shall not apply as to any fees in conjunction with the licensing of insurance producers, personal income taxes, ad valorem taxes on real or personal property, or special purpose obligations or assessments imposed by another state or by an agency of this state other than the department in connection with particular kinds of insurance other than property insurance, except that deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the commissioner in determining the propriety and extent of retaliatory action under this section.

(3) (a) For the purposes of this section the domicile of an alien insurer, other than insurers formed under the laws of Canada, shall be that state designated by the insurer in writing filed with the commissioner at time of admission to this state or within 6 months after January 1, 1961, whichever date is the later, and may be any one of the following states:

(i) that in which the insurer was first authorized to transact insurance;

(ii) that in which is located the insurer's principal place of business in the United States;

(iii) that in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

(b) If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

History: En. Sec. 71, Ch. 286, L. 1959; R.C.M. 1947, 40-2826; amd. Sec. 9, Ch. 303, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 4, Ch. 798, L. 1991.

Cross-References

Holding of retaliatory deposit, 33-2-602, 33-2-603.

Levy on retaliatory deposit by claimant or judgment debtor, 33-2-610.

Release of retaliatory deposit, 33-2-612.

33-2-710. Premium tax imposed on policy issued through nonresident licensee. Any insurer who issues a policy on a subject or risk located or to be performed in Montana through a nonresident licensee shall pay a premium tax on such policy to the state of Montana, in an amount and in the manner provided in 33-2-705.

History: En. Sec. 4, Ch. 395, L. 1983.

Cross-References

Nonresident licensee to pay taxes — annual report required, 33-17-407.

33-2-711. Terminated. Sec. 6, Ch. 706, L. 1985.

History: En. Sec. 2, Ch. 706, L. 1985.

33-2-712. Genetics program fee. Except as provided in 33-2-713, for each Montana resident insured under any individual or group disability or health insurance policy on February 1 of each year, the insurer or health service corporation issuing the policy, and the state group health plan provided for in Title 2, chapter 18, part 8, shall pay a fee of $1 to the commissioner. The fee must be paid on or before March 1 of each year and be deposited in an account in the state special revenue fund provided for in 50-19-212. The fee may be used only to fund the statewide genetics program established in 50-19-211.

History: En. Sec. 1, Ch. 554, L. 1987; amd. Sec. 1, Ch. 155, L. 1989; amd. Sec. 1, Ch. 638, L. 1991; amd. Sec. 1, Ch. 396, L. 2005; amd. Sec. 1, Ch. 377, L. 2007.

33-2-713. Group disability policy exemption. The fee required in 33-2-712 does not apply to blanket group disability insurance as defined in Title 33, chapter 22, part 6, where the total premium charged per person is less than $10 a year. For these policies, the fee is to be assessed on the basis of the number of blanket group policyholders in Montana.

History: En. Sec. 2, Ch. 554, L. 1987.

33-2-714. Health service corporation fee. (1) An authorized health service corporation as defined in 33-30-101 shall file with the commissioner, on or before March 1 of each year, a report in a format prescribed by the commissioner showing the total direct premium income during the preceding calendar year from all sources after deducting from the income applicable cancellations, returned premiums, or the amount of reduction in or refund of premiums.

(2) At the time the report is filed, and subject to 33-2-709, the health service corporation shall pay a fee to the commissioner on net premium income computed at the rate of 1%.

(3) If a health service corporation fails to pay the fee required under this section, the commissioner may:

(a) suspend or revoke the certificate of authority for the health service corporation; and

(b) impose a fine of $100 plus interest on the delinquent amount at an annual interest rate of 12%.

(4) The commissioner may provide by rule a quarterly schedule for the payment of the fee.

(5) The commissioner shall deposit money collected from the fee into the Montana HELP Act special revenue account provided for in 53-6-1315.

(6) The fee required under this section applies to a formerly authorized health service corporation if the corporation received premiums during the preceding calendar year while doing business as an authorized health service corporation in this state.

History: En. Sec. 6, Ch. 415, L. 2019.

Compiler's Comments

Contingent Termination Provision Repealed: Section 2, Ch. 35, L. 2025, repealed sec. 48, Ch. 415, L. 2019, which terminated this section on occurrence of a contingency. Effective March 27, 2025.

Contingent Termination: Section 48(1) and (2), Ch. 415, L. 2019, provided: "(1) If a court of final disposition finds that the community engagement requirements provided for in [section 1] [53-6-1308] are invalid, [this act] terminates June 30, 2025.

(2) It is the intent of the legislature that if the contingency provided for in subsection (1) occurs, the legislature has an opportunity to consider issues of program integrity, reform, and cost-effectiveness to determine whether [this act] should continue."

33-2-715 through 33-2-720 reserved.

33-2-721. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 1, Ch. 615, L. 1979; amd. Sec. 1, Ch. 60, L. 1983.

33-2-722. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 2, Ch. 615, L. 1979.

33-2-723. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 3, Ch. 615, L. 1979; amd. Sec. 1, Ch. 713, L. 1989.

33-2-724. Repealed. Sec. 64, Ch. 503, L. 2021.

History: En. Sec. 8, Ch. 582, L. 2003.

33-2-725 through 33-2-735 reserved.

33-2-736. Terminated. Sec. 39(9), Ch. 15, Sp. L. July 1992.

History: En. Sec. 31, Ch. 15, Sp. L. July 1992.

Part 8
Investments
(Repealed)

33-2-801. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 98, Ch. 286, L. 1959; R.C.M. 1947, 40-3101.

33-2-802. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 99, Ch. 286, L. 1959; R.C.M. 1947, 40-3102.

33-2-803. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 100, Ch. 286, L. 1959; R.C.M. 1947, 40-3103; amd. Sec. 23, Ch. 379, L. 1995.

33-2-804. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 130, Ch. 286, L. 1959; R.C.M. 1947, 40-3133.

33-2-805. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 101, Ch. 286, L. 1959; R.C.M. 1947, 40-3104.

33-2-806. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 102, Ch. 286, L. 1959; R.C.M. 1947, 40-3105; amd. Sec. 4, Ch. 534, L. 1987; amd. Sec. 24, Ch. 379, L. 1995; amd. Sec. 9, Ch. 531, L. 1997.

33-2-807 through 33-2-810 reserved.

33-2-811. Repealed. Sec. 50, Ch. 304, L. 1999.

History: (1)En. Sec. 103, Ch. 286, L. 1959; Sec. 40-3106, R.C.M. 1947; (2)En. Sec. 104, Ch. 286, L. 1959; Sec. 40-3107, R.C.M. 1947; R.C.M. 1947, 40-3106, 40-3107.

33-2-812. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 105, Ch. 286, L. 1959; R.C.M. 1947, 40-3108.

33-2-813. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 106, Ch. 286, L. 1959; R.C.M. 1947, 40-3109.

33-2-814. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 107, Ch. 286, L. 1959; R.C.M. 1947, 40-3110.

33-2-815. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 108, Ch. 286, L. 1959; R.C.M. 1947, 40-3111.

33-2-816. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 109, Ch. 286, L. 1959; R.C.M. 1947, 40-3112.

33-2-817. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 110, Ch. 286, L. 1959; R.C.M. 1947, 40-3113; amd. Sec. 1, Ch. 411, L. 1989.

33-2-818. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 111, Ch. 286, L. 1959; R.C.M. 1947, 40-3114.

33-2-819. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 112, Ch. 286, L. 1959; R.C.M. 1947, 40-3115.

33-2-820. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 113, Ch. 286, L. 1959; R.C.M. 1947, 40-3116; amd. Sec. 25, Ch. 379, L. 1995.

33-2-821. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 114, Ch. 286, L. 1959; R.C.M. 1947, 40-3117.

33-2-822. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 115, Ch. 286, L. 1959; R.C.M. 1947, 40-3118; amd. Sec. 3, Ch. 570, L. 1979.

33-2-823. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 116, Ch. 286, L. 1959; R.C.M. 1947, 40-3119.

33-2-824. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 117, Ch. 186, L. 1959; R.C.M. 1947, 40-3120.

33-2-825. Repealed. Sec. 50, Ch. 304, L. 1999.

History: En. Sec. 118, Ch. 286, L. 1959; R.C.M. 1947, 40-3121.

33-2-826. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 119, Ch. 286, L. 1959; R.C.M. 1947, 40-3122.

33-2-827. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 120, Ch. 286, L. 1959; R.C.M. 1947, 40-3123; amd. Sec. 55, Ch. 10, L. 1993.

33-2-828. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 121, Ch. 286, L. 1959; R.C.M. 1947, 40-3124.

33-2-829. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 122, Ch. 286, L. 1959; R.C.M. 1947, 40-3125; amd. Sec. 1, Ch. 713, L. 1989.

33-2-830. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 123, Ch. 286, L. 1959; amd. Sec. 1, Ch. 20, L. 1961; R.C.M. 1947, 40-3126; amd. Sec. 4, Ch. 570, L. 1979; amd. Sec. 143, Ch. 42, L. 1997; amd. Sec. 1, Ch. 94, L. 1997.

33-2-831. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 124, Ch. 286, L. 1959; R.C.M. 1947, 40-3127.

33-2-832. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 125, Ch. 286, L. 1959; amd. Sec. 1, Ch. 16, L. 1961; R.C.M. 1947, 40-3128; amd. Sec. 5, Ch. 570, L. 1979.

33-2-833. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 1, Ch. 5, Ex. L. 1933; amd. Sec. 1, Ch. 37, L. 1935; re-en. Sec. 5309.35, R.C.M. 1935; amd. Sec. 1, Ch. 24, L. 1937; R.C.M. 1947, 35-142(part); amd. Sec. 11, Ch. 198, L. 1979.

33-2-834 through 33-2-840 reserved.

33-2-841. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 126, Ch. 286, L. 1959; R.C.M. 1947, 40-3129.

33-2-842. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 127, Ch. 286, L. 1959; R.C.M. 1947, 40-3130.

33-2-843. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 128, Ch. 286, L. 1959; R.C.M. 1947, 40-3131.

33-2-844 through 33-2-850 reserved.

33-2-851. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 129, Ch. 286, L. 1959; R.C.M. 1947, 40-3132; amd. Sec. 17, Ch. 519, L. 1985; amd. Sec. 3, Ch. 713, L. 1989.

33-2-852. Repealed. Sec. 50, Ch. 304, L. 1999.
History: En. Sec. 131, Ch. 286, L. 1959; R.C.M. 1947, 40-3134.

Part 9
Rehabilitation and Liquidation (Repealed)

33-2-901. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 566, Ch. 286, L. 1959; R.C.M. 1947, 40-5101.

33-2-902. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 567, Ch. 286, L. 1959; R.C.M. 1947, 40-5102.

33-2-903. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 568, Ch. 286, L. 1959; R.C.M. 1947, 40-5103.

33-2-904. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 569, Ch. 286, L. 1959; R.C.M. 1947, 40-5104.

33-2-905. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 570, Ch. 286, L. 1959; R.C.M. 1947, 40-5105.

33-2-906. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 571, Ch. 286, L. 1959; R.C.M. 1947, 40-5106.

33-2-907. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 572, Ch. 286, L. 1959; R.C.M. 1947, 40-5107.

33-2-908. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 573, Ch. 286, L. 1959; R.C.M. 1947, 40-5108.

33-2-909. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 574, Ch. 286, L. 1959; R.C.M. 1947, 40-5109.

33-2-910 through 33-2-914 reserved.

33-2-915. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 575, Ch. 286, L. 1959; R.C.M. 1947, 40-5110.

33-2-916. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 576, Ch. 286, L. 1959; R.C.M. 1947, 40-5111.

33-2-917. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 577, Ch. 286, L. 1959; R.C.M. 1947, 40-5112.

33-2-918. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 578, Ch. 286, L. 1959; R.C.M. 1947, 40-5113.

33-2-919 and 33-2-920 reserved.

33-2-921. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 579, Ch. 286, L. 1959; R.C.M. 1947, 40-5114.

33-2-922. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 580, Ch. 286, L. 1959; R.C.M. 1947, 40-5115.

33-2-923. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 585, Ch. 286, L. 1959; R.C.M. 1947, 40-5120.

33-2-924. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 587, Ch. 286, L. 1959; R.C.M. 1947, 40-5122.

33-2-925. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 588, Ch. 286, L. 1959; R.C.M. 1947, 40-5123.

33-2-926. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 589, Ch. 286, L. 1959; R.C.M. 1947, 40-5124.

33-2-927. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 591, Ch. 286, L. 1959; R.C.M. 1947, 40-5126.

33-2-928. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 590, Ch. 286, L. 1959; R.C.M. 1947, 40-5125.

33-2-929 and 33-2-930 reserved.

33-2-931. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 581, Ch. 286, L. 1959; R.C.M. 1947, 40-5116.

33-2-932. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 582, Ch. 286, L. 1959; R.C.M. 1947, 40-5117.

33-2-933. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 595, Ch. 286, L. 1959; R.C.M. 1947, 40-5130.

33-2-934. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 583, Ch. 286, L. 1959; R.C.M. 1947, 40-5118.

33-2-935. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 592, Ch. 286, L. 1959; amd. Sec. 1, Ch. 200, L. 1977; R.C.M. 1947, 40-5127(2).

33-2-936. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 592, Ch. 286, L. 1959; amd. Sec. 1, Ch. 200, L. 1977; R.C.M. 1947, 40-5127(1).

33-2-937. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 584, Ch. 286, L. 1959; R.C.M. 1947, 40-5119.

33-2-938. Repealed. Sec. 61, Ch. 383, L. 1979.
History: En. Sec. 594, Ch. 286, L. 1959; R.C.M. 1947, 40-5129.

33-2-939. Repealed. Sec. 61, Ch. 383, L. 1979.
History: **En. Sec. 593, Ch. 286, L. 1959; R.C.M. 1947, 40-5128.**

33-2-940 through 33-2-944 reserved.

33-2-945. Repealed. Sec. 61, Ch. 383, L. 1979.
History: **En. Sec. 596, Ch. 286, L. 1959; R.C.M. 1947, 40-5131.**

33-2-946. Repealed. Sec. 61, Ch. 383, L. 1979.
History: **En. Sec. 597, Ch. 286, L. 1959; R.C.M. 1947, 40-5132.**

33-2-947. Repealed. Sec. 61, Ch. 383, L. 1979.
History: **En. Sec. 598, Ch. 286, L. 1959; R.C.M. 1947, 40-5133.**

33-2-948. Repealed. Sec. 61, Ch. 383, L. 1979.
History: **En. 40-5134 by Sec. 2, Ch. 200, L. 1977; R.C.M. 1947, 40-5134.**

Part 10

Stock Transfers — Holding Companies (Repealed)

33-2-1001. Repealed. Sec. 1, Ch. 239, L. 1979.
History: **En. Sec. 2, Ch. 269, L. 1967; R.C.M. 1947, 40-5502(part).**

33-2-1002. Repealed. Sec. 1, Ch. 239, L. 1979.
History: **En. Sec. 3, Ch. 269, L. 1967; R.C.M. 1947, 40-5503.**

33-2-1003. Repealed. Sec. 1, Ch. 239, L. 1979.
History: **En. Sec. 4, Ch. 269, L. 1967; R.C.M. 1947, 40-5504.**

33-2-1004. Repealed. Sec. 1, Ch. 239, L. 1979.
History: **En. Sec. 5, Ch. 269, L. 1967; R.C.M. 1947, 40-5505.**

33-2-1005. Repealed. Sec. 1, Ch. 239, L. 1979.
History: **En. Sec. 6, Ch. 269, L. 1967; R.C.M. 1947, 40-5506.**

33-2-1006. Repealed. Sec. 1, Ch. 239, L. 1979.
History: **En. Sec. 7, Ch. 269, L. 1967; R.C.M. 1947, 40-5507.**

33-2-1007. Repealed. Sec. 1, Ch. 239, L. 1979.
History: **En. Sec. 8, Ch. 269, L. 1967; R.C.M. 1947, 40-5508.**

Part 11

Affiliation and Merger — Holding Company Systems — Own Risk and Solvency Assessment

33-2-1101. Definitions. As used in this part, the following definitions apply unless the context requires otherwise:

(1) An "affiliate" of or person "affiliated" with a specific person is a person that directly, or indirectly through one or more intermediaries, controls or is controlled by or is under common control with the person specified.

(2) "Control", including the terms "controlling", "controlled by", and "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person. This power may be evidenced through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided by 33-2-1112 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(3) "Enterprise risk" means any activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material

adverse effect on the financial condition or liquidity of the insurer or its insurance holding company system as a whole. The term includes but is not limited to anything that would cause the insurer's risk-based capital to fall into a company action level, as provided in 33-2-1904, or that would cause the insurer to be in hazardous financial condition as determined by the commissioner pursuant to 33-2-1321.

(4) "Groupwide supervisor" means the regulatory official authorized to engage in conducting and coordinating groupwide supervision activities who is determined or acknowledged by the commissioner under 33-2-1140 to have sufficient significant contacts with the internationally active insurance group.

(5) "Group capital calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(6) "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

(7) "Insurer" has the meaning provided in 33-1-201, except that the term does not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(8) "Internationally active insurance group" means an insurance holding company system that includes an insurer registered under 33-2-1111 and meets the following criteria:

(a) premiums are written in at least three countries;

(b) the percentage of gross premiums written outside the United States is at least 10% of the insurance holding company system's total gross written premiums; and

(c) based on a 3-year rolling average, the total assets of the insurance holding company system are at least $50 billion or the total gross written premiums of the insurance holding company system are at least $10 billion.

(9) "NAIC" means the national association of insurance commissioners.

(10) "NAIC liquidity stress test framework" means a separate NAIC publication that includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, the scope criteria, instructions, and reporting template as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(11) (a) "Person" means an individual, a corporation, a partnership, an association, a joint-stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing acting in concert.

(b) The term does not include any securities broker performing no more than the usual and customary broker's function.

(12) The "scope criteria", as detailed in the NAIC liquidity stress test framework, are the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

(13) A "securityholder" of a specified person is one who owns any security of that person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

(14) A "subsidiary" of a specified person is an affiliate controlled by that person directly or indirectly through one or more intermediaries.

(15) "Voting security" means any security convertible into or evidencing a right to acquire a voting security.

History: En. Sec. 1, Ch. 64, L. 1971; R.C.M. 1947, 40-5509(part); amd. Sec. 23, Ch. 370, L. 2015; amd. Sec. 1, Ch. 344, L. 2021.

33-2-1102. Authorization of subsidiaries. Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

(1) any kind of insurance business authorized by the jurisdiction in which it is incorporated;

(2) acting as an insurance broker or as an insurance producer for its parent or for any of its parent's insurer subsidiaries;

(3) investing, reinvesting, or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;

(4) management of any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

(5) acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

(6) rendering investment advice to governments, government agencies, corporations, or other organizations or groups;

(7) rendering other services related to the operations of an insurance business, including but not limited to actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal, and collection services;

(8) ownership and management of assets which the parent corporation could itself own or manage;

(9) acting as administrative agent for a governmental instrumentality which is performing an insurance function;

(10) financing of insurance premiums, insurance producers, and other forms of consumer financing;

(11) any other business activity determined by the commissioner to be reasonable ancillary to an insurance business;

(12) owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

History: En. Sec. 2, Ch. 64, L. 1971; R.C.M. 1947, 40-5510(a); amd. Sec. 1, Ch. 713, L. 1989.

33-2-1103. Additional investment authority — exemption from other investment restrictions — determination of qualification — divestiture. (1) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under this part, a domestic insurer may also:

(a) invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of 10% of the insurer's assets or 50% of the insurer's surplus as regards policyholders, provided that after the investments the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, there must be included total net money or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary, whether or not represented by the purchase of capital stock or issuance of other securities, and all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities and all contributions to the capital or surplus of a subsidiary subsequent to its acquisition or formation.

(b) if the insurer's total liabilities, as calculated for national association of insurance commissioners annual statement purposes, are less than 10% of assets, invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, provided that after the investment the insurer's surplus as regards policyholders, considering the investment as if it were a disallowed asset, will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs;

(c) invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, provided that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in this section. The total investment of the insurer must include:

(i) any direct investment by the insurer in an asset;

(ii) the insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which is calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership of such subsidiary.

(d) with the approval of the commissioner, invest a greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries, provided that after the investment, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) Investments in common stock, preferred stock, debt obligations, or other securities of subsidiaries made pursuant to subsection (1) are not subject to any of the otherwise applicable restrictions or prohibitions contained in this part applicable to such investments of insurers.

(3) Whether any investment pursuant to subsection (1) meets the applicable requirements thereof is to be determined immediately after the investment is made, taking into account the then outstanding principal balance on all previous investments in debt obligations and the value of all previous investments in equity securities as of the date they were made.

(4) If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within 3 years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after the investment is made, the investment meets the requirements for investment under any other section of this part and the insurer has notified the commissioner thereof.

History: **En. Sec. 2, Ch. 64, L. 1971; R.C.M. 1947, 40-5510(b) thru (e); amd. Sec. 12, Ch. 198, L. 1979; amd. Sec. 142, Ch. 575, L. 1981; amd. Sec. 2, Ch. 620, L. 1989.**

33-2-1104. Acquisition or divestiture of control of or merger with domestic insurer — filing requisites. (1) (a) A person other than the issuer may not make a tender offer for or a request or invitation for tenders of or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation of the transaction, the person would, directly or indirectly or by conversion or by exercise of any right to acquire, be in control of the insurer.

(b) A person may not enter into an agreement to merge with or otherwise to acquire control of a domestic insurer unless, at the time any offer, request, or invitation is made or any agreement is entered into or prior to the acquisition of the securities if an offer or agreement is not involved, the person has filed with the commissioner and has sent to the insurer, and the insurer has sent to its shareholders, a statement as provided in subsection (3) containing the information required by this section and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner prescribed in this section.

(2) (a) A controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer in any manner shall file a statement as provided in subsection (3) with the commissioner for approval of its proposed divestiture at least 30 days prior to the cessation of control.

(b) The information in the notice must remain confidential until the conclusion of the transaction unless the commissioner, at the commissioner's discretion, determines confidential treatment will interfere with enforcement of this section.

(3) The statement to be filed with the commissioner must be made under oath or affirmation and must contain the following:

(a) the name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) is to be effected, who is called the "acquiring party":

(i) if the person is an individual, the principal occupation and all offices and positions held during the past 5 years and any conviction of crimes other than minor traffic violations during the past 10 years;

(ii) if the person is not an individual:

(A) a report of the nature of its business operations during the past 5 years or for a lesser period that the person and any predecessors have been in existence;

(B) an informative description of the business intended to be done by the person and the person's subsidiaries; and

(C) a list of all individuals who are or who have been selected to become directors or executive officers of the person or who perform or will perform functions appropriate to the positions. The list must include for each individual the information required by subsection (3)(a)(i).

(b) the source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction in which funds were or are to be obtained for any purpose, and the identity of persons furnishing the consideration, provided that when a source of consideration is a loan made in the lender's ordinary course of business, the identity of the lender must remain confidential if the person filing the statement requests;

(c) fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding 5 fiscal years of each acquiring party, or for a lesser period that the acquiring party and any predecessors have been in existence, and similar unaudited information as of a date not earlier than 90 days prior to the filing of the statement;

(d) any plans or proposals that each acquiring party may have to liquidate the insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management;

(e) the number of shares of any security referred to in subsection (1) that each acquiring party proposes to acquire and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection (1) and a statement as to the method by which the fairness of the proposal was arrived at;

(f) the amount of each class of any security referred to in subsection (1) that is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(g) a full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection (1) in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description must identify the persons with whom the contracts, arrangements, or understandings have been entered into.

(h) a description of the purchase of any security referred to in subsection (1) by an acquiring party during the 12 calendar months preceding the filing of the statement, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid for the security;

(i) a description of any recommendations to purchase any security referred to in subsection (1) during the 12 calendar months preceding the filing of the statement made by any acquiring party or by anyone based upon interviews or at the suggestion of the acquiring party;

(j) copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection (1) and, if distributed, of additional soliciting material relating to the offers or agreements;

(k) the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of securities referred to in subsection (1) for tender and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard to the solicitation;

(l) an agreement by which the person required to file the statement referred to in subsection (1) agrees to provide the annual enterprise risk report for as long as control exists;

(m) an acknowledgment by the person required to file the statement referred to in subsection (1) that the person and all affiliates within its control in the insurance holding company system agree to provide information to the commissioner upon request if the commissioner determines the information is necessary to evaluate enterprise risk to the insurer; and

(n) additional information that the commissioner may by rule prescribe as necessary or appropriate for the protection of policyholders and securityholders of the insurer or in the public interest.

(4) If the person required to file the statement referred to in subsection (1) is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information called for by subsection (3) must be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in subsection (1) is a corporation, the commissioner may require that the information required by subsection (3) be given with respect

to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than 10% of the outstanding voting securities of the corporation.

(5) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment describing the change, together with copies of all documents and other material relevant to the change, must be filed with the commissioner and sent to the insurer within 2 business days after the person learns of the change. The insurer shall send the amendment to its shareholders.

(6) If any offer, request, invitation, agreement, or acquisition referred to in subsection (1) is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934 or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) may use the documents in furnishing the information called for by that statement.

(7) As used in this section:

(a) "domestic insurer" includes any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in a business other than the business of insurance;

(b) "person" does not include a securities broker holding, in the usual and customary broker's function, less than 20% of the voting securities of an insurance company or of any person who controls an insurance company.

History: **En. Sec. 3, Ch. 64, L. 1971; R.C.M. 1947, 40-5511(a) thru (c); amd. Sec. 1090, Ch. 56, L. 2009; amd. Sec. 24, Ch. 370, L. 2015; amd. Sec. 11, Ch. 9, L. 2017.**

Cross-References

Promulgation of rules, Title 2, ch. 4, part 3; 33-1-313.
Securities Act of Montana, Title 30, ch. 10.

33-2-1105. Approval by commissioner — hearings — notice. (1) The commissioner shall approve any merger or other acquisition or divestiture of control referred to in 33-2-1104 unless, after a public hearing, the commissioner finds that:

(a) after the change of control, the domestic insurer referred to in 33-2-1104 would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which the domestic insurer is presently licensed;

(b) the effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly;

(c) the financial condition of any acquiring party might jeopardize the financial stability of the insurer or prejudice the interest of the insurer's policyholders or the interests of any remaining securityholders who are unaffiliated with the acquiring party;

(d) the terms of the offer, request, invitation, agreement, or acquisition referred to in 33-2-1104 are unfair and unreasonable to the securityholders of the insurer;

(e) the plans or proposals that the acquiring party has to liquidate the insurer, to sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(f) the competence, experience, and integrity of those persons who would control the operation of the insurer are of the nature that the change in control would not be in the interest of policyholders of the insurer and of the public; or

(g) the acquisition is likely to be hazardous or prejudicial to the insurance-buying public.

(2) The public hearing referred to in subsection (1) must be held within 30 days after the statement required by 33-2-1104(1) is filed, and at least 20 days' notice of the hearing must be given by the commissioner to the person filing the statement. Not less than 7 days' notice of the public hearing must be given by the person filing the statement to the insurer and to other persons as may be designated by the commissioner. The insurer shall give notice to its securityholders. The commissioner shall make a determination within 30 days after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interests may be affected has the right to present evidence, examine and cross-examine witnesses, and offer oral and written

arguments and to conduct discovery proceedings in the same manner that is presently allowed in the district court of this state. All discovery proceedings must be concluded not later than 3 days prior to the commencement of the public hearing.

(3) All statements, amendments, or other material filed pursuant to 33-2-1104(1) through (5) and all notices of public hearings held pursuant to subsection (1) of this section must be mailed by the insurer to its shareholders within 5 business days after the insurer has received the statements, amendments, other material, or notices. The expenses of mailing must be borne by the person making the filing. As security for the payment of the expenses, the person shall file with the commissioner an acceptable bond or other deposit in an amount to be determined by the commissioner.

(4) The commissioner may retain at the expense of the acquiring or divesting party any attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

History: En. Sec. 3, Ch. 64, L. 1971; R.C.M. 1947, 40-5511(d), (e); amd. Sec. 3, Ch. 620, L. 1989; amd. Sec. 1091, Ch. 56, L. 2009; amd. Sec. 25, Ch. 370, L. 2015; amd. Sec. 12, Ch. 9, L. 2017.

Cross-References

Administrative hearings, Title 2, ch. 4, part 6.

33-2-1106. Exemptions — violations — jurisdiction. (1) The provisions of 33-2-1104 and 33-2-1105 do not apply to an offer, request, invitation, agreement, or acquisition that the commissioner by order exempts from those sections as:

(a) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer; or

(b) otherwise not comprehended within the purposes of 33-2-1104 and 33-2-1105.

(2) The following are violations of 33-2-1104 or 33-2-1105:

(a) the failure to file any statement, amendment, or other material required to be filed pursuant to 33-2-1104(1) through (5);

(b) the effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with a domestic insurer unless the commissioner has given approval.

(3) The courts of this state are vested with jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the commissioner under 33-2-1104 and over all actions involving the person arising out of violations of 33-2-1104 or 33-2-1105. Each person is considered to have performed acts equivalent to and constituting an appointment of the commissioner to be the person's attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of this section. Copies of all lawful process must be served on the commissioner and transmitted by certified mail by the commissioner to the person at the person's last-known address.

History: En. Sec. 3, Ch. 64, L. 1971; R.C.M. 1947, 40-5511(f) thru (h); amd. Sec. 4, Ch. 620, L. 1989; amd. Sec. 1092, Ch. 56, L. 2009; amd. Sec. 26, Ch. 370, L. 2015; amd. Sec. 5, Ch. 62, L. 2019.

Cross-References

Service of process — Commissioner as attorney for service, Title 33, ch. 1, part 6.

33-2-1107 through 33-2-1110 reserved.

33-2-1111. Registration of insurers — requisites — termination. (1) (a) An insurer authorized to do business in this state that is a member of an insurance holding company system shall register with the commissioner, except that a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile that are substantially similar to those contained in this section is not required to register.

(b) Any insurer subject to registration under this section shall register within 15 days after becoming subject to registration, unless the commissioner for good cause extends the time for registration.

(c) The commissioner may require any authorized insurer that is a member of a holding company system that is not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority in the jurisdiction where the company is domiciled.

(2) An insurer subject to registration shall file with the commissioner, on or before April 30 each year, a registration statement on a form provided by the commissioner that must contain current information about:

(a) the capital structure, general financial condition, ownership, and management of the insurer and any person controlling the insurer;

(b) the identity and relationship of every member of the insurance holding company system;

(c) transactions currently outstanding or that occurred during the last calendar year between the insurer and its affiliates and the following agreements that are in force:

(i) loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) purchases, sales, or exchanges of assets;

(iii) transactions not in the ordinary course of business;

(iv) guaranties or undertakings for the benefit of an affiliate that result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) management and service contracts and cost-sharing arrangements;

(vi) reinsurance agreements;

(vii) dividends and other distributions to shareholders; and

(viii) consolidated tax allocation agreements;

(d) a pledge of the insurer's stock, including stock of a subsidiary or controlling affiliate for a loan made to a member of the insurance holding company system;

(e) if requested by the commissioner, financial statements of or within an insurance holding company system, including all affiliates, which may include annual audited financial statements filed with the U.S. securities and exchange commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, or the most recently filed parent corporation financial statements filed with the U.S. securities and exchange commission;

(f) statements that the insurer's board of directors is responsible for and oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, have implemented, and continue to maintain and monitor corporate governance and internal control procedures;

(g) all matters concerning transactions between registered insurers and any affiliates as may be included from time to time in registration forms adopted or approved by the commissioner; and

(h) any other information required by the commissioner by rule.

(3) A registration statement must contain a summary outlining each item in the current registration statement that represents a change from the prior registration statement.

(4) Information need not be disclosed on the registration statement filed pursuant to subsection (2) if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments involving 1/2 of 1% or less of an insurer's admitted assets as of the prior December 31 are not material for purposes of this section. The definition of materiality provided in this subsection does not apply for purposes of the group capital calculation of the liquidity stress test framework.

(5) A person within an insurance holding company system subject to registration shall provide complete and accurate information to an insurer if the information is reasonably necessary to enable the insurer to comply with Title 33, chapter 2, part 11.

(6) Each registered insurer shall keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within 15 days after the end of the month in which the registered insurer learns of each change or addition.

(7) (a) The ultimate controlling person of every insurer subject to registration under this section shall also file an annual enterprise risk report. The report must identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer to the best of the controlling person's knowledge and belief. The report must be filed

with the lead state commissioner of the insurance holding company system, as determined by the procedures within the financial analysis handbook adopted by rule of the commissioner.

(b) Except as provided in this section, the ultimate controlling person of every insurer subject to registration shall concurrently file with the registration an annual group capital calculation as directed by the lead state commissioner. The report must be completed in accordance with the NAIC group capital calculation instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report must be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the financial analysis handbook adopted by the NAIC. Insurance holding company systems described below are exempt from filing the group capital calculation:

(i) an insurance holding company system that has only one insurer within its holding company structure, that only writes business and is only licensed in its domestic state, and assumes no business from any other insurer;

(ii) an insurance holding company system that is required to perform a group capital calculation specified by the United States federal reserve board. The lead state commissioner shall request the calculation from the federal reserve board under the terms of information-sharing agreements in effect. If the federal reserve board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing.

(iii) an insurance holding company system whose non-U.S. groupwide supervisor is located within a reciprocal jurisdiction as described in 33-2-1216 that recognizes the U.S. state regulatory approach to group supervision and group capital;

(iv) an insurance holding company system:

(A) that provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the groupwide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC financial analysis handbook; and

(B) whose non-U.S. groupwide supervisor that is not in a reciprocal jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the worldwide group capital assessment for U.S. insurance groups who operate in that jurisdiction;

(v) notwithstanding the provisions of subsections (7)(b)(iii) and (7)(b)(iv), a lead state commissioner shall require the group capital calculation for U.S. operations of any non-U.S. based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace;

(vi) notwithstanding the exemptions from filing the group capital calculation stated in subsections (7)(b)(i) through (7)(b)(iv), the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation;

(vii) if the lead state commissioner determines that an insurance holding company system no longer meets one or more of the requirements for an exemption from filing the group capital calculation under this section, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown;

(c) The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test. The filing must be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the financial analysis handbook adopted by the NAIC:

(i) The NAIC liquidity stress test framework includes scope criteria applicable to a specific data year. These scope criteria are reviewed at least annually by the financial stability task force or its successor. Any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured are effective on January 1 of the year following the calendar year when such changes are adopted. Insurers meeting at least one threshold of the scope criteria are considered scoped into the NAIC liquidity stress test framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC financial stability task force or its successor, determines the insurer should not be scoped into the framework for that data year. Similarly, insurers that do not trigger at least one threshold of the scope criteria are considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC financial stability task force or its successor, determines the insurer should be scoped into the framework for that data year.

(ii) Regulators wish to avoid having insurers scoped in and out of the NAIC liquidity stress test framework on a frequent basis. The lead state insurance commissioner, in consultation with the financial stability task force or its successor, will assess this concern as part of the determination for an insurer.

(iii) The performance of, and filing of the results from, a specific year's liquidity stress test must comply with the NAIC liquidity stress test framework's instructions and reporting templates for that year and any lead state insurance commissioner determinations, in conjunction with the financial stability task force or its successor, provided within the framework.

(8) The commissioner shall terminate the registration of any insurer that demonstrates that the insurer no longer is a member of an insurance holding company system.

(9) The commissioner may require or allow two or more affiliated insurers subject to registration under this section to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

(10) The commissioner may allow an insurer that is authorized to do business in this state and that is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under subsection (1) and to file all information and material required to be filed under this section.

History: En. Sec. 4, Ch. 64, L. 1971; R.C.M. 1947, 40-5512(a) thru (g); amd. Sec. 5, Ch. 620, L. 1989; amd. Sec. 45, Ch. 596, L. 1993; amd. Sec. 26, Ch. 379, L. 1995; amd. Sec. 27, Ch. 370, L. 2015; amd. Sec. 13, Ch. 9, L. 2017; amd. Sec. 2, Ch. 344, L. 2021.

33-2-1112. Exemptions — disclaimer — violations. (1) The provisions of 33-2-1111 and this section do not apply to any insurer, information, or transaction to the extent that the commissioner by rule or order has exempted that insurer, information, or transaction from the provisions of 33-2-1111 and this section.

(2) (a) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer, or a disclaimer may be filed by an insurer or any member of an insurance holding company system. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurer that is the object of the disclaimer as well as the basis for disclaiming the affiliation.

(b) The commissioner shall approve or deny a disclaimer within 30 days of filing. If the commissioner denies a disclaimer under this section, the disclaiming party may request a hearing, which must be granted. The disclaiming party is not required to register under this section if the commissioner approves the disclaimer.

(3) The failure to file a registration statement, any summary of the registration statement, an enterprise risk report, or any amendment to the registration statement or enterprise risk report, as required by 33-2-1111 and this section, within the time specified for filing is a violation of 33-2-1111 and this section.

History: En. Sec. 4, Ch. 64, L. 1971; R.C.M. 1947, 40-5512(h) thru (j); amd. Sec. 28, Ch. 370, L. 2015; amd. Sec. 14, Ch. 275, L. 2017.

Cross-References

Promulgation of rules, Title 2, ch. 4, part 3; 33-1-313.

33-2-1113. Transactions with affiliates — standards. (1) Material transactions by registered insurers with their affiliates are subject to the following standards:

(a) The terms must be fair and reasonable.

(b) Charges or fees for services performed must be reasonable.

(c) Expenses incurred and payments received must be allocated to the insurer in conformity with customary insurance accounting practices consistently applied.

(d) The books, accounts, and records of each party must clearly and accurately disclose the precise nature and details of the transactions, including any accounting information necessary to support the reasonableness of the charges or fees to the respective parties.

(e) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates must be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) (a) The following transactions involving a domestic insurer and a person in its holding company system, including amendments or modifications to affiliate agreements previously filed under this section, may not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into a transaction within at least 30 days prior to the transaction, or a shorter period as the commissioner may permit, and the commissioner does not disapprove the transaction:

(i) sales, purchases, exchanges, loans or extensions of credit, guaranties, or investments if, as of the prior December 31, the transactions are equal to or exceed:

(A) with respect to insurers other than life insurers, the lesser of 3% of the insurer's admitted assets or 25% of its surplus as regards policyholders; and

(B) with respect to life insurers, 3% of the insurer's admitted assets;

(ii) loans or extensions of credit to a person who is not an affiliate if the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in an affiliate of the insurer making the loans or extensions of credit if the transactions, as of the prior December 31, are equal to or exceed:

(A) with respect to insurers other than life insurers, the lesser of 3% of the insurer's admitted assets or 25% of its surplus as regards policyholders;

(B) with respect to life insurers, 3% of the insurer's admitted assets;

(iii) reinsurance agreements or modifications to reinsurance agreements, including:

(A) reinsurance pooling agreements;

(B) agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next 3 years, equals or exceeds 5% of the insurer's surplus regarding policyholders as of the prior December 31; and

(C) those agreements that may require as consideration the transfer of assets from an insurer to a nonaffiliate if an agreement or understanding exists between the insurer and nonaffiliate that a portion of the assets will be transferred to one or more affiliates of the insurer;

(iv) all management agreements, service contracts, tax allocation agreements, guarantees, and cost-sharing arrangements;

(v) direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount that, together with its present holdings in such investments, exceeds 2.5% of the insurer's surplus to policyholders; and

(vi) any material transactions, specified by rule, that the commissioner determines may adversely affect the interests of the insurer's policyholders.

(b) Nothing in this subsection (2) is considered to authorize or permit a transaction that, in the case of an insurer that is not a member of the same holding company system, would otherwise be contrary to law.

(3) A domestic insurer may not enter into a transaction that is part of a plan or series of like transactions with a person within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount review. If the commissioner determines that the separate transactions were entered into over a 12-month period for the purpose of evading review, the commissioner may exercise authority under 33-2-1120.

(4) The commissioner, in reviewing a transaction pursuant to subsection (2), shall consider whether the transaction complies with the standards set forth in subsection (1) and whether the transaction may adversely affect the interests of a policyholder.

(5) The commissioner must be notified within 30 days of an investment by a domestic insurer in a corporation if the total investment in the corporation by the insurance holding company system exceeds 10% of the corporation's voting securities.

(6) For purposes of this section, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to the insurer's financial needs, the following factors, among others, must be considered:

(a) the size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria;

(b) the extent to which the insurer's business is diversified among the several lines of insurance;

(c) the number and size of risks insured in each line of business;

(d) the extent of the geographical dispersion of the insurer's insured risks;

(e) the nature and extent of the insurer's reinsurance program;

(f) the quality, diversification, and liquidity of the insurer's investment portfolio;

(g) the recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(h) the surplus as regards policyholders maintained by other comparable insurers;

(i) the adequacy of the insurer's reserves;

(j) the quality and liquidity of investments in affiliates made pursuant to 33-2-1104 and 33-2-1105. The commissioner may treat any investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the commissioner's judgment the investment so warrants.

History: En. Sec. 5, Ch. 64, L. 1971; R.C.M. 1947, 40-5513(a), (b); amd. Sec. 6, Ch. 620, L. 1989; amd. Sec. 10, Ch. 451, L. 1993; amd. Sec. 29, Ch. 370, L. 2015; amd. Sec. 14, Ch. 9, L. 2017; amd. Sec. 6, Ch. 62, L. 2019.

33-2-1114. Dividends and other distributions — commissioner approval. (1) An insurer subject to registration under 33-2-1111 and 33-2-1112 may not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until 30 days after the commissioner has received notice of the declaration of the dividend or distribution and has not within the period disapproved the payment or the commissioner has approved payment within the 30-day period.

(2) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds 10% of the insurer's surplus as regards policyholders as of December 31 next preceding, but may not include pro rata distributions of any class of the insurer's own securities.

(3) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval, and the declaration may not confer rights upon shareholders until the commissioner has approved the payment of the dividend or distribution or the commissioner has not disapproved the payment within the 30-day period referred to in subsection (1).

(4) An insurer subject to subsection (1) may not pay any other dividend or make any other distribution to its shareholders unless the insurer has notified the commissioner of the payment 15 days prior to the payment date. The notice must be kept confidential until the payment date of the dividend. The commissioner may order that a dividend not be paid if the commissioner finds that the insurer's surplus as regards policyholders, following the payment to shareholders, would be inadequate or could lead the insurer to a hazardous financial condition.

History: En. Sec. 5, Ch. 64, L. 1971; R.C.M. 1947, 40-5513(c); amd. Sec. 5, Ch. 534, L. 1987; amd. Sec. 46, Ch. 596, L. 1993.

33-2-1115. Examination. (1) (a) In addition to the powers under Title 33, chapter 1, part 4, relating to the examination of insurers, the commissioner also has the power to order any insurer registered under 33-2-1111 to produce the records, books, or other information papers in the possession of the insurer or its affiliates that the commissioner determines are necessary to ascertain the financial condition or legality of conduct of the insurer.

(b) The information that the commissioner may request under subsection (1)(a) includes information necessary to ascertain the enterprise risk to the insurer by the ultimate controlling party or by any entity or combination of entities within the insurance holding company system or by the insurance holding company system on a consolidated basis.

(c) If the insurer fails to comply with the order, the commissioner may examine the affiliates to obtain the information.

(2) The commissioner may retain at the registered insurer's expense attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff that may be reasonably necessary to assist in the conduct of the examination under subsection (1). Any persons retained are under the direction and control of the commissioner and are retained to act in a purely advisory capacity.

(3) Each registered insurer producing for examination records, books, and papers pursuant to subsection (1) is liable for and shall pay the expense of the examination.

(4) In the event the insurer fails to comply with an order, the commissioner may examine the affiliates to obtain the information.

(5) Nothing in this section limits the authority of the commissioner under 33-1-315 through 33-1-318 to issue subpoenas, administer oaths, examine under oath any person, compel testimony, issue penalties, or seek injunctions or other remedies to determine and ensure compliance with this section.

History: En. Sec. 6, Ch. 64, L. 1971; R.C.M. 1947, 40-5514; amd. Sec. 47, Ch. 596, L. 1993; amd. Sec. 30, Ch. 370, L. 2015; amd. Sec. 15, Ch. 9, L. 2017.

33-2-1116. Confidentiality of information. (1) (a) Documents, materials, and other information in the possession or control of the commissioner that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to 33-2-1115 and all other information provided to the department of insurance pursuant to 33-2-1104(3)(l), 33-2-1104(3)(m), 33-2-1111, and 33-2-1113 are confidential information as provided in 2-6-1002 and Title 2, chapter 6, part 10, are recognized by this state as being proprietary and contain trade secrets, and are confidential by law and privileged, are not subject to subpoena or discovery, and are not admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials, and other information to further any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner may not otherwise make the documents, materials, or other information public without the prior written consent of the insurer to which the documents, materials, or other information pertains unless the commissioner, after giving notice and an opportunity to be heard to the insurer and the insurer's affiliates who would be affected, determines that the interest of policyholders, shareholders, or the public would be served by the publication. On a determination that the interest of policyholders, shareholders, or the public would be served, the commissioner may publish all or any part of the documents, materials, or other information in a manner that the commissioner considers appropriate.

(b) For purposes of the information reported and provided to the department of insurance pursuant to 33-2-1111(7)(b), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the federal reserve board or any U.S. groupwide supervisor.

(c) For purposes of the information reported and provided to the department pursuant to 33-2-1111(7)(c), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the federal reserve board and non-U.S. groupwide supervisors.

(2) Neither the commissioner nor any person who receives documents, materials, or other information while acting under the authority of the commissioner, or with whom the documents, materials, or other information is shared under Title 33, chapter 2, part 4, and this section, may be required or permitted to testify in a private civil action concerning any confidential documents, materials, or information subject to subsection (1).

(3) To assist in the performance of the commissioner's duties, the commissioner:

(a) may, subject to subsection (3)(b), share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsection (1), including proprietary and trade secret documents and materials, with other state, federal, and international regulatory agencies, with the NAIC, with any third-party consultants designated by the commissioner, and with state, federal, and international law enforcement authorities, including members of a supervisory college. To receive the shared documents, materials, or other information, the recipient shall verify in writing that the recipient has the legal authority to maintain confidentiality and agree in writing to maintain the confidentiality and privileged status of the documents, materials, or other information.

(b) may share confidential and privileged documents, materials, or other information reported pursuant to 33-2-1111(7) only with insurance regulators of states having statutes or regulations substantially similar to subsection (1) and only if the respective insurance regulators have agreed in writing not to disclose the documents, materials, or other information;

(c) may receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or other information, including proprietary and trade secret information, from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions; and

(d) shall maintain as confidential or privileged any document, materials, or other information received under subsection (3)(c) with notice or the understanding that the document, materials, or other information is confidential or privileged under the laws of the jurisdiction that is the source of the document, materials, or information.

(4) (a) The commissioner shall enter into written agreements with the NAIC and any third-party consultant designated by the commissioner governing the sharing and use of information provided pursuant to Title 33, chapter 2, part 4, and this section.

(b) An agreement with the NAIC under this subsection (4) must:

(i) specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the commissioner pursuant to Title 33, chapter 2, part 4, and this section, including procedures and protocols for sharing by the NAIC with other state, federal, or international regulators. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) specify that ownership information shared with the NAIC or a third-party consultant pursuant to Title 33, chapter 2, part 4, and this section remains with the commissioner and that the NAIC's or a third-party consultant's, as designated by the commissioner, use of the information is subject to the direction of the commissioner;

(iii) excluding documents, material, or information reported pursuant to 33-2-1111, prohibit the NAIC or third-party consultant designated by the commissioner from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(iv) require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the commissioner pursuant to Title 33, chapter 2, part 4, and this section is subject to a request or a subpoena to the NAIC or a third-party consultant designated by the commissioner for disclosure or production;

(v) require the NAIC or a third-party consultant designated by the commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant designated by the commissioner may be required to disclose confidential information about the insurer that has been shared with the NAIC and its affiliates and subsidiaries pursuant to Title 33, chapter 2, part 4, and this section; and

(vi) for documents, material, or information reporting pursuant to 33-2-1111(7)(c) in the case of an agreement involving a third-party consultant, provide for notification of the identity of the consultant to the applicable insurers.

(5) The sharing of information by the commissioner pursuant to Title 33, chapter 2, part 4, and this section does not constitute a delegation of regulatory authority or rulemaking. The commissioner is solely responsible for the administration, execution, and enforcement of the provisions of Title 33, chapter 2, part 4, and this section.

(6) Disclosure to the commissioner of information under this section or as a result of sharing of confidential information authorized under subsections (3) and (4) does not constitute a

waiver of any applicable privilege or claim of confidentiality related to the information obtained under Title 33, chapter 2, part 4, and this section.

(7) Documents, materials, and other information in the possession or control of the NAIC or a third-party consultant designated by the commissioner pursuant to Title 33, chapter 2, part 4, and this section are confidential information as provided in 2-6-1002 and privileged, are not admissible in evidence in a private civil action, and are not subject to subpoena or discovery.

(8) The group capital calculation and resulting group capital ratio required under 33-2-1111 and the liquidity stress test along with its results and supporting disclosures required under 33-2-1111 are regulatory tools for assessing group risks and capital adequacy and group liquidity risks, respectively, and are not intended as a means to rank insurers or insurance holding company systems generally. Therefore, except as otherwise may be required under the provisions of this title, the making, publishing, disseminating, circulating, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station or any electronic means of communication available to the public, or in any other way as an advertisement, announcement, or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, the liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or of any component derived in the calculation by any insurer, broker, or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited. However, if any materially false statement with respect to the group capital calculation, resulting group capital ratio, an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation or resulting group capital ratio, liquidity stress test result, supporting disclosures for the liquidity stress test, or an inappropriate comparison of any amount to an insurer's or insurance group's liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement or the inappropriateness, as the case may be, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

History: En. Sec. 7, Ch. 64, L. 1971; R.C.M. 1947, 40-5515; amd. Sec. 7, Ch. 416, L. 1999; amd. Secs. 70, 71, Ch. 348, L. 2015; amd. Sec. 31, Ch. 370, L. 2015; amd. Sec. 3, Ch. 344, L. 2021.

Cross-References

Records open to public examination, Art. II, sec. 9, Mont. Const.; 2-6-1003.

33-2-1117. Rules. The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules and orders as shall be necessary to carry out the provisions of this part.

History: En. Sec. 8, Ch. 64, L. 1971; R.C.M. 1947, 40-5516.

Cross-References

Promulgation of rules, Title 2, ch. 4, part 3; 33-1-313.

33-2-1118. Injunctions. Whenever it appears to the commissioner that any insurer or any director, officer, employee, or insurance producer thereof has committed or is about to commit a violation of this part or of any rule or order issued by the commissioner hereunder, the commissioner may apply to the district court for the county in which the principal office of the insurer is located or if such insurer has no such office in this state then to the district court for Lewis and Clark County for an order enjoining such insurer or such director, officer, employee, or insurance producer thereof from violating or continuing to violate this part or any such rule or order and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

History: En. Sec. 9, Ch. 64, L. 1971; R.C.M. 1947, 40-5517(a); amd. Sec. 1, Ch. 713, L. 1989.

Cross-References

Injunctions, Title 27, ch. 19.

33-2-1119. Voting of securities — prohibition — injunction — sequestration. (1) No security which is the subject of any agreement or arrangement regarding acquisition or which is acquired or to be acquired in contravention of the provisions of this part or of any rule or order issued by the commissioner hereunder may be voted at any shareholders' meeting or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered.

(2) If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this part or of any rule or order issued by the commissioner hereunder, the insurer or the commissioner may apply to the district court for Lewis and Clark County or to the district court for the county in which the insurer has its principal place of business to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of 33-2-1113 or any rule or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors, and shareholders or the public may require.

(3) In any case where a person has acquired or is proposing to acquire any voting securities in violation of this part or any rule or order issued by the commissioner hereunder, the district court for Lewis and Clark County or the district court for the county in which the insurer has its principal place of business may, on such notice as the court deems appropriate, upon the application of the insurer or the commissioner seize or sequester any voting securities of the insurer owned directly or indirectly by such person and issue such orders with respect thereto as may be appropriate to effectuate the provisions of this part. Notwithstanding any other provisions of law, for the purposes of this part the situs of the ownership of the securities of domestic insurers shall be deemed to be in this state.

History: **En. Sec. 9, Ch. 64, L. 1971; R.C.M. 1947, 40-5517(b), (c).**

Cross-References

Injunctions, Title 27, ch. 19.

33-2-1120. Registration, transaction, and reporting requirements — administrative or civil penalties. (1) An insurer failing without just cause to file a registration statement as required in 33-2-1111 shall, after notice and hearing, pay a penalty of $100 for each day of delinquency. The maximum penalty under this subsection is $25,000. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(2) A director or an officer of an insurance holding company system who knowingly violates, participates in, or assents to a transaction or who knowingly permits an officer or insurance producer of the insurer to engage in a transaction or make an investment that has not been properly reported or submitted pursuant to 33-2-1111 or 33-2-1113 or that violates any other provision of Title 33, chapter 2, part 11, shall, after notice and hearing, pay, in the director's or officer's individual capacity, a fine of not more than $5,000 for each violation. To determine the amount of the fine, the commissioner shall consider the appropriateness of the fine with respect to the gravity of the violation, the history of previous violations, and other matters that justice may require.

(3) If the commissioner determines that an insurer subject to Title 33, chapter 2, part 11, or a director, officer, employee, or insurance producer of the insurer has engaged in a transaction or entered into a contract that is subject to 33-2-1113 and that would not have been approved had approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing, the commissioner may also order the insurer to void the contract and restore the status quo if that action is in the best interest of policyholders, creditors, or the public.

(4) Withholding of information required under 33-2-1104, if lack of that information prevents a full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, is a violation of 33-2-1104 and may serve as an independent basis for:

(a) disapproving dividends or distributions; or

(b) placing the insurer under supervision as provided in 33-2-1321.

(5) Any insurer that willfully violates this part may be fined not more than $25,000.

History: **En. Sec. 10, Ch. 64, L. 1971; R.C.M. 1947, 40-5518; amd. Sec. 7, Ch. 620, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1093, Ch. 56, L. 2009; amd. Sec. 32, Ch. 370, L. 2015; amd. Sec. 21, Ch. 396, L. 2017.**

Cross-References

Criminal Procedure, Title 46.

33-2-1121. Receivership. Whenever it appears to the commissioner that any person has committed a violation of this part which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, then the commissioner may proceed to take possession of the property of such domestic insurer and to conduct the business thereof.

History: **En. Sec. 11, Ch. 64, L. 1971; R.C.M. 1947, 40-5519.**

Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.

33-2-1122. Revocation, suspension, or nonrenewal of insurer's license. Whenever it appears to the commissioner that any person has committed a violation of this part that makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke, or refuse to renew the insurer's license or authority to do business in this state for a period that the commissioner finds is required for the protection of policyholders or the public. Any determination must be accompanied by specific findings of fact and conclusions of law.

History: **En. Sec. 12, Ch. 64, L. 1971; R.C.M. 1947, 40-5520; amd. Sec. 1094, Ch. 56, L. 2009.**

Cross-References

Contested administrative cases, 2-4-102; Title 2, ch. 4, part 6.

Licenses — withdrawal or revocation, 2-4-631.

33-2-1123. Judicial review — mandamus. (1) Any person aggrieved by any act, determination, rule, or order or any other action of the commissioner pursuant to this part may appeal therefrom to the district court for Lewis and Clark County. The court shall conduct its review without a jury and by trial de novo, except that if all parties, including the commissioner, so stipulate, the review shall be confined to the record. Portions of the record may be introduced by stipulation into evidence in a trial de novo as to those parties so stipulating.

(2) The filing of an appeal pursuant to this section shall stay the application of any such rule, order, or other action of the commissioner to the appealing party unless the court, after giving such party notice and an opportunity to be heard, determines that such a stay would be detrimental to the interests of policyholders, shareholders, creditors, or the public.

(3) Any person aggrieved by any failure of the commissioner to act or make a determination required by this part may petition the district court for Lewis and Clark County for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make such determination forthwith.

History: **En. Sec. 13, Ch. 64, L. 1971; R.C.M. 1947, 40-5521.**

Cross-References

Mandamus, Title 27, ch. 26.

Appeals from Commissioner's decision, 33-1-711.

33-2-1124. Conflict with other laws. All laws and parts of laws of this state inconsistent with this part are hereby superseded with respect to matters covered by this part.

History: **En. Sec. 14, Ch. 64, L. 1971; R.C.M. 1947, 40-5522.**

33-2-1125. Recovery of dividends. (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order has a right to recover on behalf of the insurer:

(a) from any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions, other than distributions of shares of the same class of stock, paid by the insurer on its capital stock; or

(b) any payment in the form of a bonus, termination settlement, or extraordinary lump-sum salary adjustment made by the insurer or its subsidiary to a director, officer, or employee, when the distribution or payment pursuant to subsection (1)(a) or this subsection is made at any time during the year preceding the petition for liquidation, conservation, or rehabilitation, as the case may be, subject to the limitations of subsections (2) through (4).

(2) A distribution is not recoverable if the parent or affiliate shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time that the distributions were paid is liable up to the amount of distributions or payments that the person received. Any person who otherwise controlled the insurer at the time that the distributions were declared is liable up to the amount of distributions the person would have received if the person had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(4) The maximum amount recoverable under this section is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(5) To the extent that any person liable under subsection (3) is insolvent or otherwise fails to pay claims due from it, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid is jointly and severally liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

History: **En. Sec. 48, Ch. 596, L. 1993.**

33-2-1126 through 33-2-1129 reserved.

33-2-1130. Short title. Sections 33-2-1130 through 33-2-1138 may be cited as the "Own Risk and Solvency Assessment Act".

History: **En. Sec. 1, Ch. 370, L. 2015.**

33-2-1131. Purpose. The purpose of sections 33-2-1130 through 33-2-1138 is to provide:

(1) requirements for maintaining a risk management framework and completing an own risk and solvency assessment; and

(2) guidance and instructions for filing an ORSA summary report with the commissioner.

History: **En. Sec. 2, Ch. 370, L. 2015.**

33-2-1132. Definitions. For the purposes of 33-2-1130 through 33-2-1138, the following definitions apply:

(1) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in 33-2-1101.

(2) "NAIC" means the national association of insurance commissioners.

(3) "ORSA guidance manual" means the current version of the own risk and solvency assessment guidance manual developed and adopted by the NAIC as of April 30, 2015, or as subsequently adopted by rule by the commissioner. A change to the ORSA guidance manual is effective on January 1 following the calendar year in which the commissioner adopts the changed manual by rule.

(4) "ORSA summary report" means a confidential, high-level summary of an insurer's or insurance group's ORSA.

(5) "Own risk and solvency assessment" or "ORSA" means a confidential, internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by an insurer or insurance group, of the material and relevant risks associated with the insurer or the insurance group's current business plan and of the sufficiency of the insurer's or insurance group's capital resources to support those risks.

(6) "Risk management framework" means a study of the elements used to assist an insurer or insurance group to identify, assess, monitor, manage, and report on material and relevant risk of the insurer or the insurance group.

History: **En. Sec. 3, Ch. 370, L. 2015.**

33-2-1133. Risk management framework required. All Montana insurers and insurance groups shall maintain a risk management framework. This requirement is satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

History: **En. Sec. 4, Ch. 370, L. 2015.**

33-2-1134. Own risk and solvency assessment required. Subject to the exemptions in 33-2-1136, an insurer or an insurance group of which the insurer is a member shall conduct an own risk and solvency assessment consistent with a process comparable to the ORSA guidance manual. The own risk and solvency assessment must be conducted no less than annually and at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

History: **En. Sec. 5, Ch. 370, L. 2015.**

33-2-1135. ORSA summary report. (1) No more than once a year, the commissioner may request and an insurer or its insurance group shall provide to the commissioner, as provided in subsection (2), an ORSA summary report or any combination of reports that together contain the information described in the ORSA guidance manual as applicable to the insurer and the insurance group of which the insurer is a member.

(2) (a) If the insurer is a member of an insurance group, the insurer shall submit any report required under this section to the commissioner when the commissioner is the lead state regulator for that insurance group.

(b) If the insurer is not a member of an insurance group, the insurer shall submit any report required under this section to the commissioner.

(c) An insurer that is a member of an insurance group may voluntarily submit the report to a requesting insurance regulator who is not the lead state regulator for the insurer's insurance group.

(3) (a) The report must be prepared consistent with the ORSA guidance manual and subsection (3)(b). Documentation and supporting information must be maintained and made available for an examination on request of the commissioner.

(b) The review of the ORSA summary report and any additional requests for information must be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

(4) (a) The report must include the signature of the chief risk officer of the insurer or insurance group or of another executive charged with overseeing the enterprise risk management process for the insurer or the insurance group.

(b) The signature of the chief risk officer or other executive charged with overseeing the enterprise risk management is an attestation that to the best of the officer's or executive's knowledge the insurer or insurance group applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the board of directors of the insurer or the insurance group or to the appropriate committee of the board of directors.

(5) An insurer may comply with this section by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which the insurer is a member to the insurance regulator of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA guidance manual. A report in a language other than English must be accompanied by a translation of the report into English.

History: **En. Sec. 6, Ch. 370, L. 2015.**

33-2-1136. ORSA exemptions — conditions — waiver — override. (1) Except as provided in subsection (5), an insurer is exempt from the requirements of 33-2-1130 through 33-2-1138 if:

(a) (i) the insurer has an annual direct written and unaffiliated assumed premium of less than $500 million. This total includes international direct and assumed premiums. The total excludes premiums reinsured through the federal crop insurance corporation and the federal flood program.

(ii) the insurer's insurance group has annual direct written and unaffiliated assumed premiums of less than $1 billion. This total includes international direct and assumed premiums. The total excludes premiums reinsured through the federal crop insurance corporation and the federal flood program.

(b) the insurer provides the most recent and similar report provided by the insurer or another group member of an insurance group of which the insurer is a member to the insurance regulator of another state or to an insurance supervisor or insurance regulator of a foreign jurisdiction.

(2) If an insurer qualifies for exemption pursuant to subsection (1)(a)(i) but the insurance group of which the insurer is a member does not qualify for exemption pursuant to subsection (1)(a)(ii), the ORSA summary report must include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA summary report for any combination of insurers as long as each combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to (1)(a)(i) but the insurance group of which the insurer is a member qualifies for exemption pursuant to subsection (1)(a)(ii), the only required ORSA summary report is the report applicable to that insurer.

(4) (a) An insurer that does not qualify for exemption under this section may apply to the commissioner for a waiver from the requirements of 33-2-1130 through 33-2-1138 based on unique circumstances.

(b) In deciding whether to grant an insurer's request for a waiver, the commissioner may consider the type and volume of business written, ownership, organizational structure, and any other factor the commissioner considers relevant to the insurer or to the insurance group of which the insurer is a member.

(c) If the insurer is part of an insurance group with insurers domiciled in more than one state, the commissioner may coordinate with the lead state regulator and with the other domiciliary insurance regulators in considering whether to grant the insurer's request for a waiver.

(5) (a) The commissioner may override the exemptions provided under this section:

(i) based on unique circumstances, which may include the type and volume of business written, ownership, organizational structure, federal agency requests, or international supervisor requests;

(ii) if the insurer has risk-based capital that meets a company action level event as provided in 33-2-1904;

(iii) if the insurer is in hazardous financial condition as described in 33-2-1321; or

(iv) if the insurer exhibits the qualities of a troubled insurer as determined by the commissioner.

(b) If the commissioner determines that an override of the exemptions as provided in subsection (5)(a) is necessary, the commissioner may require an insurer to maintain a risk management framework, conduct an own risk and solvency assessment, and file an ORSA summary report.

(6) If an insurer qualifies for an exemption pursuant to subsection (1) but subsequently no longer qualifies for that exemption because of changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer has 1 year following the year in which the threshold was exceeded to comply with the requirements of 33-2-1130 through 33-2-1138.

History: **En. Sec. 7, Ch. 370, L. 2015.**

33-2-1137. Confidentiality. (1) Information provided or developed under 33-2-1130 through 33-2-1138 for an own risk and solvency assessment or ORSA summary report and in the possession of or control of the commissioner or any other person under 33-2-1130 through 33-2-1138 is recognized as proprietary and containing trade secrets. The information is confidential information as provided in 2-6-1002 and privileged, is not admissible in evidence in any civil action, and is not subject to subpoena, discovery, or the provisions of the Freedom of Information Act, 5 U.S.C. 552.

(2) The commissioner may use information in an ORSA summary report in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(3) The commissioner and any person who receives ORSA-related information while operating under the authority of the commissioner or with whom information is shared pursuant

to an own risk and solvency assessment may not testify in any private civil action concerning the ORSA-developed information.

(4) To assist in the commissioner's regulatory duties, the commissioner:

(a) may, on request, share ORSA-related information, including proprietary and trade secret documents and materials, with other state, federal, and international financial regulatory agencies, including with members of any supervisory college, the NAIC, or third-party consultants designated by the commissioner. A person with whom the ORSA-related information is shared shall agree in writing to maintain the confidentiality and privileged status of the ORSA-related information and shall verify in writing that the recipient has legal authority to maintain confidentiality.

(b) may receive ORSA-related information, including otherwise confidential and privileged documents, materials, or other information that may include proprietary and trade secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, supervisory college members, and the NAIC. Received information is confidential as provided in this section.

(c) shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of the information provided pursuant to an ORSA, consistent with this subsection (4).

(5) The written agreement required under subsection (4)(c) must:

(a) specify procedures and protocols regarding the confidentiality of the information, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers;

(b) provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the information and that the recipient has verified the legal authority to maintain confidentiality;

(c) specify that ownership of shared information remains with the commissioner. Use of the information by the NAIC or a third-party consultant is subject to the direction of the commissioner.

(d) prohibit the recipient from storing the shared information in a permanent database after any underlying analysis is completed;

(e) require prompt notice to be given to an insurer whose information in the possession of the recipient is subject to a request or subpoena to the recipient for disclosure or production;

(f) require the recipient to consent to intervention by an insurer in any judicial or administrative action in which the recipient may be required to disclose confidential information about the insurer that is received under an ORSA; and

(g) require the insurer's consent when entering into an agreement with a third-party consultant.

(6) The sharing of information pursuant to 33-2-1130 through 33-2-1138 does not constitute a delegation of regulatory authority or rulemaking, and the commissioner remains solely responsible for the administration, execution, and enforcement of the provisions of 33-2-1130 through 33-2-1138.

(7) Disclosure of information under this section to or from the commissioner does not constitute a waiver of any applicable privilege or claim of confidentiality related to the information obtained under 33-2-1130 through 33-2-1138.

(8) Information in the possession of or control of the NAIC or a third-party consultant pursuant to 33-2-1130 through 33-2-1138 is confidential information as provided in 2-6-1002 and privileged, is not admissible in evidence in any private civil action, and is not subject to subpoena or discovery.

(9) For the purposes of this section, "information" means documents, materials, or other ORSA-related information, including the ORSA summary report, that is in the possession of or control of the commissioner or any other person under 33-2-1130 through 33-2-1138.

History: En. Sec. 8, Ch. 370, L. 2015; amd. Secs. 67, 68, Ch. 348, L. 2015.

33-2-1138. Penalty. (1) Any insurer failing to timely file the ORSA summary report shall be fined no more than $500 for each day's delay, up to a maximum penalty of $25,000.

(2) The commissioner shall collect the fine and deposit the money in the state general fund.

History: En. Sec. 9, Ch. 370, L. 2015.

33-2-1139 reserved.

33-2-1140. Groupwide supervision of internationally active insurance groups. (1) (a) The commissioner is authorized to act as the groupwide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the commissioner may otherwise acknowledge another regulatory official as the groupwide supervisor where the internationally active insurance group:

(i) does not have substantial insurance operations in the United States;

(ii) has substantial insurance operations in the United States, but not in this state; or

(iii) has substantial insurance operations in the United States and this state, but the commissioner has determined pursuant to the factors set forth in subsections (2) and (6) that the other regulatory official is the appropriate groupwide supervisor.

(b) An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a groupwide supervisor pursuant to this section.

(2) (a) In cooperation with other state, federal, and international regulatory agencies, the commissioner will identify a single groupwide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate groupwide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate groupwide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection (2):

(i) the place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets, or liabilities;

(ii) the place of domicile of the top-tiered insurers in the insurance holding company system of the internationally active insurance group;

(iii) the location of the executive offices or largest operational offices of the internationally active insurance group;

(iv) whether another regulatory official is acting or is seeking to act as the groupwide supervisor under a regulatory system that the commissioner determines to be substantially similar to the system of regulation provided under the laws of this state, or otherwise sufficient in terms of providing for groupwide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(v) whether another regulatory official acting or seeking to act as the groupwide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

(b) However, a commissioner identified under this section as the groupwide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the groupwide supervisor. The acknowledgment of the groupwide supervisor shall be made after consideration of the factors listed in subsections (2)(a)(i) through (2)(a)(v) and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group and in consultation with the internationally active insurance group.

(3) Notwithstanding any other provision of law, when another regulatory official is acting as the groupwide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the groupwide supervisor. However, in the event of a material change in the internationally active insurance group that results in the internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities or this state being the place of domicile of the top-tiered insurers in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate groupwide supervisor for such an internationally active insurance group pursuant to subsection (2).

(4) Pursuant to 33-2-1115, the commissioner is authorized to collect from any insurer registered pursuant to 33-2-1111 all information necessary to determine whether the commissioner may act as the groupwide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the groupwide supervisor. Prior to issuing a determination that an internationally active insurance group

is subject to groupwide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to this section and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group has not less than 30 days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the Montana administrative register and on its internet website the identity of internationally active insurance groups that the commissioner has determined are subject to groupwide supervision by the commissioner.

(5) If the commissioner is the groupwide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following groupwide supervision activities:

(a) assess the enterprise risks within the internationally active insurance group to ensure that:

(i) the material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(ii) reasonable and effective mitigation measures are in place;

(b) request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including but not limited to information about the members of the internationally active insurance group regarding:

(i) governance, risk assessment, and management;

(ii) capital adequacy; and

(iii) material intercompany transactions;

(c) coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(d) communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information, subject to the confidentiality provisions of 33-2-1116, through supervisory colleges as provided for in Title 33, chapter 2, part 11, or otherwise;

(e) enter into agreements with or obtain documentation from any insurer registered under 33-2-1111, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as groupwide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation may not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(f) other groupwide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

(6) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the groupwide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with groupwide supervision undertaken by the groupwide supervisor, provided that:

(a) the commissioner's cooperation is in compliance with the laws of this state; and

(b) the regulatory official acknowledged as the groupwide supervisor also recognizes and cooperates with the commissioner's activities as a groupwide supervisor for other internationally active insurance groups where applicable. When such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

(7) The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under 33-2-1111, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance group that provide the basis for or otherwise clarify a regulatory official's role as groupwide supervisor.

(8) The commissioner may promulgate rules necessary for the administration of this section.

(9) A registered insurer subject to this section is liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals and all reasonable travel expenses.

History: **En. Sec. 4, Ch. 344, L. 2021.**

Part 12
Limit of Risk — Reinsurance

33-2-1201. Limit of risk. (1) An insurer may not retain any risk on any one subject of insurance, whether located or to be performed in this state or elsewhere, in an amount exceeding 10% of its surplus to policyholders.

(2) A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake, or other catastrophe hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of the other hazard insured against.

(3) Reinsurance ceded as authorized by this part must be deducted in determining risk retained. As to surety risks, deduction must also be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for the surety's protection.

(4) As to alien insurers, this section only relates to risks and surplus to policyholders of the insurer's United States branch.

(5) "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, is considered to include any voluntary reserves which are not required pursuant to law and are determined from the last sworn statement of the insurer on file with the commissioner or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(6) This section does not apply to life or disability insurance, title insurance, insurance of wet marine and transportation risks, workers' compensation insurance, employer's liability coverages, or any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

History: **En. Sec. 80, Ch. 286, L. 1959; R.C.M. 1947, 40-2909; amd. Sec. 49, Ch. 596, L. 1993; amd. Sec. 27, Ch. 379, L. 1995.**

33-2-1202 through 33-2-1204 reserved.

33-2-1205. Repealed. Sec. 71, Ch. 596, L. 1993.

History: **En. Sec. 81, Ch. 286, L. 1959; R.C.M. 1947, 40-2910; amd. Sec. 8, Ch. 620, L. 1989.**

33-2-1206. Bulk reinsurance — foreign or alien insurers. (1) A foreign or alien insurer may reinsure all or substantially all of its insurance in force in Montana or a major class of insurance with an agreement of bulk reinsurance, but the agreement may not become effective unless filed with the commissioner and approved by the commissioner in writing. The commissioner may hold a hearing before approving or disapproving an agreement of bulk reinsurance. Factors to be considered on bulk reinsurance agreements include but are not limited to:

(a) whether the agreement would be inequitable to Montana policyholders;

(b) whether the agreement would substantially reduce security of Montana policyholders; and

(c) whether the agreement would substantially reduce the service to be rendered to Montana policyholders.

(2) The commissioner shall approve or disapprove the agreement within a reasonable time after filing the proposed agreement or, when applicable, after a hearing.

(3) The commissioner may require a foreign or alien insurer to establish a trust account in this state, not to exceed the aggregate reserves of the policies contained in the bulk reinsurance agreement, prior to granting approval.

History: En. 40-2911 by Sec. 1, Ch. 303, L. 1977; R.C.M. 1947, 40-2911; amd. Sec. 4, Ch. 518, L. 1983; amd. Sec. 1095, Ch. 56, L. 2009.

Cross-References

Appeals from Commissioner's decision, 33-1-711.

33-2-1207. Interest in reinsurance. The original insured has no interest in a contract of reinsurance.

History: En. Sec. 280, Ch. 286, L. 1959; R.C.M. 1947, 40-3723.

33-2-1208 through 33-2-1210 reserved.

33-2-1211. Bulk reinsurance — stock insurers. (1) A domestic stock insurer may reinsure all or substantially all of its insurance in force or a major class of insurance with another insurer by an agreement of bulk reinsurance, but the agreement may not become effective unless filed with the commissioner and approved by the commissioner in writing after a hearing on the agreement.

(2) The commissioner shall approve an agreement within a reasonable time after filing unless the commissioner finds that it is inequitable to the stockholders of the domestic insurer or would substantially reduce the protection or service to its policyholders. If the commissioner does not approve the agreement, the commissioner shall notify the insurer in writing specifying the reasons for disapproval.

History: En. Sec. 464, Ch. 286, L. 1959; R.C.M. 1947, 40-4747; amd. Sec. 1096, Ch. 56, L. 2009.

Cross-References

Appeals from Commissioner's decision, 33-1-711.

33-2-1212. Bulk reinsurance — mutual insurers. (1) A domestic mutual insurer may reinsure all or substantially all its business in force, or all or substantially all of a major class of its business, with another insurer, stock or mutual, by an agreement of bulk reinsurance after compliance with this section. An agreement may not become effective unless filed with the commissioner and approved by the commissioner in writing after a hearing on the agreement.

(2) The commissioner shall approve an agreement within a reasonable time after filing if the commissioner finds it to be fair and equitable to each domestic insurer involved and that the reinsurance if effectuated would not substantially reduce the protection or service to its policyholders. If the commissioner does not approve the agreement, the commissioner shall notify each insurer involved in writing specifying the reasons for disapproval.

(3) The plan and agreement for reinsurance must be approved by vote of not less than two-thirds of each domestic mutual insurer's members voting on the plan and agreement at meetings of members called for the purpose, pursuant to reasonable notice and procedure that the commissioner may approve. If the insurer is a life insurer, the right to vote may be limited to members whose policies are other than term or group policies and have been in effect for more than 1 year.

(4) If the agreement is for reinsurance of a mutual insurer in a stock insurer, the agreement must provide for payment in cash to each member of the insurer entitled to a payment upon conversion of the insurer, pursuant to 33-3-216, of the member's equity in the business reinsured as determined under a fair formula approved by the commissioner. The equity must be based upon the member's equity in the reserves, assets, whether or not "admitted" assets, and surplus, if any, of the mutual insurer to be taken over by the stock insurer.

History: En. Sec. 465, Ch. 286, L. 1959; R.C.M. 1947, 40-4748; amd. Sec. 1097, Ch. 56, L. 2009.

Cross-References

Appeals from Commissioner's decision, 33-1-711.

33-2-1213 through 33-2-1215 reserved.

33-2-1216. Credit allowed domestic ceding insurer — rulemaking. (1) Credit for reinsurance is allowed to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of subsection (2), (3), (4), (5), (6), (7), or (8). Credit must be allowed under subsection (2), (3), or (4) only in respect to cessions of those kinds or classes of business that the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which the branch of the alien assuming insurer entered and is licensed to transact insurance or reinsurance. If the requirements of subsection (4) or (5) are met, the requirements of subsection (9) must also be met.

(2) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(3) Credit must be allowed when the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state. Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation has been revoked by the commissioner after notice and hearing. An accredited reinsurer is one that:

(a) files with the commissioner evidence of its submission to this state's jurisdiction;

(b) submits to this state's authority to examine its books and records;

(c) is licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(d) files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(e) demonstrates to the satisfaction of the commissioner that the accredited reinsurer has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer meets this requirement as of the time of its application if:

(i) the assuming accredited reinsurer maintains a surplus with regard to policyholders in an amount not less than $20 million; and

(ii) the commissioner approves its accreditation within 90 days after the date that the accredited reinsurer submits its application.

(4) (a) Subject to subsection (4)(b), credit must be allowed when:

(i) the reinsurance is ceded to an assuming insurer that is domiciled and licensed in or, in the case of a United States branch of an alien assuming insurer, is entered through a state that employs standards regarding credit for reinsurance substantially similar to those applicable under this statute; and

(ii) the assuming insurer or the United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20 million; and

(B) submits to the authority of this state to examine its books and records.

(b) The requirement of subsection (4)(a)(i) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(5) (a) Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund. The assuming insurer shall submit to examination of its books and records by the commissioner and shall bear the expense of examination.

(b) (i) In the case of a single assuming insurer, the trust must consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States, and in addition, the assuming insurer shall maintain a surplus with the trustee of not less than $20 million, except as provided in subsection (5)(b)(ii).

(ii) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least 3 full years, the insurance regulator with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus after a finding that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows. The risk assessment must consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(iii) In the case of a group, including incorporated and individual unincorporated underwriters, the trust must consist of a trusteed account representing the respective underwriters' liabilities attributable to business written in the United States to any underwriter of the group. Additionally, the group shall maintain a surplus with the trustee of which $100 million must be held jointly for the benefit of United States ceding insurers of any member of the group. The incorporated members of the group, as group members, may not be engaged in a business other than underwriting as members of the group and are subject to the same level of solvency regulation and control by the insurance regulator as the unincorporated members. Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification of the solvency of each underwriter by the insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled.

(iv) In the case of a group of incorporated insurers under common administration:

(A) the provisions of subsection (5)(b)(iv)(B) apply to the group that:

(I) complies with the reporting requirements contained in subsection (5)(a);

(II) has continuously transacted an insurance business outside the United States for at least 3 years immediately prior to making application for accreditation;

(III) submits to this state's authority to examine its books and records and bears the expense of the examination; and

(IV) has aggregate policyholders' surplus of $10 billion;

(B) (I) the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

(II) the group shall maintain a joint surplus with a trustee of which $100 million is held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any liabilities; and

(III) within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, each member of the group shall provide to the commissioner an annual certification of the member's solvency by the insurance regulator and the independent public accountants in the jurisdiction where the underwriter is domiciled.

(c) The trust must be established in a form approved by the commissioner. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the commissioner. The trust described in this subsection (5)(c) must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(d) No later than February 28 of each year, the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the end of the preceding year. The trustees shall certify the date of termination of the trust, if planned, or certify that the trust may not expire prior to the following December 31.

(6) (a) The commissioner shall allow credit when the reinsurance is ceded to an assuming insurer that the commissioner has certified as a reinsurer in this state and secures its obligation in accordance with the requirements of this subsection (6).

(b) To be eligible for certification under this subsection (6), an assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction as determined by the commissioner pursuant to subsection (6)(d) and shall:

(i) maintain minimum capital and surplus or its equivalent as promulgated by the commissioner by rule;

(ii) maintain financial strength ratings from two or more rating agencies, as determined by the commissioner;

(iii) agree to the jurisdiction of this state;

(iv) appoint a registered agent for service of process in this state as required by 33-1-605;

(v) agree to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if the assuming insurer resists enforcement of a final judgment from within the United States;

(vi) agree to meet applicable information filing requirements as determined by the commissioner; and

(vii) satisfy any other requirements for certification considered relevant by the commissioner.

(c) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer. The incorporated members of the association may not engage in any business other than underwriting as a member of the association. The incorporated members are subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members. In order to be eligible for certification under this subsection (6)(c), the association shall satisfy the requirements of this subsection (6)(c) and shall:

(i) satisfy its minimum capital and surplus requirements through the capital and surplus equivalents as a net of liabilities of the association and its members. This provision must include use of a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members in an amount that provides adequate protection as determined by the commissioner.

(ii) provide to the commissioner, within 90 days of the date its financial statements are due to be filed with the association's domiciliary regulator, an annual certification by the association's domiciliary regulator of the solvency of each underwriter member. If a certification is unavailable, the association may provide a financial statement prepared by independent public accountants of each underwriter member.

(d) The commissioner shall create, maintain, and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in a qualified jurisdiction is eligible to be considered for certification as a certified reinsurer. The commissioner shall certify all United States jurisdictions as long as those jurisdictions are accredited under the NAIC financial standards and accreditation program. For jurisdictions not in the United States, the commissioner may defer to a list of qualified jurisdictions published by the NAIC or, if the commissioner does not defer to the NAIC list, shall develop a list of qualified jurisdictions by considering:

(i) the reinsurance supervisory system of the jurisdiction;

(ii) the rights, benefits, and extent of reciprocal recognition afforded by the jurisdiction to reinsurers licensed and domiciled within the United States;

(iii) whether an NAIC-accredited jurisdiction has certified the reinsurer; and

(iv) any additional factors the commissioner considers relevant.

(e) If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions published by the NAIC, the commissioner shall provide thoroughly documented justification in accordance with the criteria listed under subsection (6)(d).

(f) Qualified jurisdictions under subsection (6)(d) shall agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction.

(g) The commissioner may not approve a jurisdiction not in the United States if the commissioner determines that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards.

(h) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may either suspend the reinsurer's certification indefinitely or revoke the certification entirely.

(i) The commissioner shall assign a rating to each certified reinsurer. In assigning a rating, the commissioner shall consider the financial strength ratings assigned by agencies approved by the commissioner. The commissioner shall publish a list of all certified reinsurers and their ratings. The commissioner may defer to a rating assigned by a jurisdiction accredited by the NAIC.

(j) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this subsection (6)(j) at a level consistent with the certified reinsurer's rating. A domestic ceding insurer qualifies for full financial statement credit for reinsurance ceded to a certified reinsurer if the certified reinsurer:

(i) maintains security in a form acceptable to the commissioner and in accord with the provisions of this section; or

(ii) forms a multibeneficiary trust in accord with subsections (5)(a) through (5)(d), except that minimum trusteed surplus requirements as provided in subsection (5)(b) do not apply with respect to a multibeneficiary trust account maintained by a certified reinsurer for the purpose of securing obligations incurred under this subsection (6)(j). A multibeneficiary trust under this subsection (6)(j)(ii) must be maintained with a minimum trusteed surplus of $10 million.

(k) A certified reinsurer operating under subsection (6)(j)(ii) shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this subsection (6) or comparable laws of other United States jurisdictions.

(l) If obligations incurred by a certified reinsurer under this subsection (6) lack sufficient security, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency. The commissioner may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(m) For the purposes of this subsection (6), a certified reinsurer whose certification has been terminated for any reason must be treated as a certified reinsurer required to secure 100% of its obligations. If the commissioner assigns a higher rating to a certified reinsurer on inactive status pursuant to this subsection (6)(m), this subsection (6)(m) does not apply. As used in this subsection (6)(m), "terminated" refers to a reinsurer whose certificate of authority has been revoked, suspended, voluntarily surrendered, or put on inactive status.

(n) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this subsection (6), and the commissioner shall assign a rating that takes into account, if relevant, the reasons the reinsurer is not assuming new business.

(7) (a) Credit must be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth below:

(i) The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction. A "reciprocal jurisdiction" is a jurisdiction that meets one of the following criteria:

(A) a non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this subsection (7), a "covered agreement" is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in Montana or for allowing the ceding insurer to recognize credit for reinsurance.

(B) a U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(C) a qualified jurisdiction as determined by the commissioner pursuant to subsection (6)(d), which is not otherwise described in subsection (7)(a)(i)(A) or (7)(a)(i)(B) above and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in rule.

(ii) The assuming insurer must have and maintain, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be set forth in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts to be set forth in rule.

(iii) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio, as applicable, provided in rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed.

(iv) The assuming insurer shall agree and provide adequate assurance to the commissioner, in a form specified by the commissioner pursuant to rules, as follows:

(A) The assuming insurer shall provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements in subsection (7)(a)(ii) or (7)(a)(iii), or if any regulatory action is taken against it for serious noncompliance with applicable law.

(B) The assuming insurer shall consent in writing to the jurisdiction of the Montana courts and to appoint a registered agent for service of process in Montana as required by 33-1-605. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent the agreements are unenforceable under applicable insolvency or delinquency law.

(C) The assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained.

(D) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to the agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate.

(E) The assuming insurer shall confirm that it is not presently participating in any solvent scheme of arrangement which involves Montana's ceding insurers and agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. The security must be in a form consistent with the provisions of 33-2-1217 and subsection (7) of this section and as specified by the commissioner through rule.

(v) The assuming insurer or its legal successor shall provide, if requested by the commissioner, on behalf of itself and any legal successors, certain documentation to the commissioner, as specified by the commissioner through rule.

(vi) The assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth through rule.

(vii) The assuming insurer's supervisory authority shall confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements in subsections (7)(a)(ii) and(7)(a)(iii).

(viii) Nothing in this section precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(b) The commissioner shall create and publish a timely list of reciprocal jurisdictions.

(i) A list of reciprocal jurisdictions is published through the NAIC committee process. The commissioner's list must include any reciprocal jurisdiction as defined under subsections (7)(a)(i)(A) and (7)(a)(i)(B) and must consider any other reciprocal jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions in accordance with criteria established by the commissioner through rule.

(ii) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth by the commissioner through rule, except that the commissioner may not remove from the list a reciprocal jurisdiction as defined under subsections (7)(a)(i)(A) and (7)(a)(i)(B). Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction must be allowed, if otherwise allowed pursuant to this section.

(c) The commissioner shall create and publish a timely list of assuming insurers that have satisfied the conditions set forth in this subsection (7) and to which cessions must be granted credit in accordance with this subsection (7). The commissioner may add an assuming insurer to the list if an NAIC accredited jurisdiction has added the assuming insurer to a list of the assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under subsection (7)(a)(iv) and complies with any additional requirements that the commissioner may impose through rule, except to the extent that they conflict with an applicable covered agreement.

(d) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this subsection (7), the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection (7) in accordance with procedures set forth in rule.

(i) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with 33-2-1217.

(ii) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of 33-2-1217.

(e) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(f) Nothing in this subsection (7) shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this section or other applicable law or regulation.

(g) (i) Credit may be taken under this subsection (7) only for reinsurance agreements entered into, amended, or renewed on or after March 23, 2021, adding this subsection, and only with respect to losses incurred and reserves reported on or after the later of:

(A) the date on which the assuming insurer has met all eligibility requirements pursuant to this subsection (7) herein; and

(B) the effective date of the new reinsurance agreement, amendment, or renewal.

(ii) This subsection (7) does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection (7), as long as the reinsurance qualifies for credit under any other applicable provision of this section.

(iii) Nothing in this subsection (7):

(A) authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement; and

(B) limits, or in any way alters, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(8) Credit must be allowed when the reinsurance is ceded to an assuming insurer that does not meet the requirements of subsection (2), (3), (4), (5), (6), (7), or (8), but only with respect to the insurance of risks located in a jurisdiction in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(9) (a) If the assuming insurer is not licensed, accredited, or certified to transact insurance or reinsurance in this state, the credit permitted by subsections (4), (5), (6), and (7) may not be allowed unless the assuming insurer agrees in the reinsurance agreements to the following provisions:

(i) upon the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of any court of competent jurisdiction in any state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of any appellate court in the event of an appeal; and

(ii) the assuming insurer shall designate the commissioner or a designated attorney as its attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding insurer.

(b) Subsection (9)(a)(i) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes if an obligation is created in the agreement.

(10) (a) If the assuming insurer does not meet the requirements of subsection (1), (2), or (3), the credit permitted by subsection (4), (5), (6), or (7) may not be allowed unless the assuming insurer agrees in the trust agreements to the conditions under subsections (10)(b) through (10)(d).

(b) Regardless of any other provisions in the trust instrument, the trustee shall comply with an order of the commissioner or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner all assets of the trust fund if:

(i) the trust fund is inadequate because the trust fund contains an amount less than the required amount; or

(ii) the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation, or similar proceedings.

(c) The assets transferred under subsection (10)(a) must be distributed by the commissioner. Claims must be filed with and valued by the commissioner in accordance with the laws of the state in which the trust is domiciled and that apply to the liquidation of domestic insurers.

(d) The commissioner may determine that the assets of the trust fund or any part of the trust fund assets are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust. If the commissioner makes this determination, the commissioner shall return the assets or part of the assets to the trustee for distribution in accordance with the trust agreement.

(11) (a) The commissioner may suspend or revoke a reinsurer's accreditation or certification if the reinsurer ceases to meet the requirements of this section. The commissioner shall give the reinsurer notice and opportunity for a hearing. The suspension or revocation may not take effect until after the commissioner's order on hearing unless:

(i) the reinsurer waives its right to a hearing;

(ii) the commissioner's order is based on:

(A) regulatory action by the reinsurer's domiciliary jurisdiction; or

(B) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction; or

(iii) the commissioner finds that an emergency requires immediate action.

(b) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit under this section except to the extent that the reinsurer's obligations under the contract are secured in accordance with this section. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with 33-2-1217 and subsection (6)(j) of this section.

(12) (a) A ceding insurer shall take steps:

(i) to manage the reinsurance recoverables proportionate to the ceding insurer's own book of business. A domestic ceding insurer shall provide notice to the commissioner within 30 days after:

(A) the reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders; or

(B) a determination that the reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers is likely to exceed the limit in subsection (12)(a)(i)(A).

(ii) to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within 30 days after ceding to any single assuming insurer or group of affiliated assuming insurers more than 20% of the ceding insurer's gross written premium in the prior calendar year or after the domestic ceding insurer has determined that the reinsurance ceded to any single assuming insurer or group of affiliated assuming insurers is likely to exceed the 20% limit.

(b) The notifications made pursuant to this subsection (12) must demonstrate that the exposure is safely managed by the domestic ceding insurer.

(13) A reinsurance contract issued or renewed after the effective date of a suspension or revocation does not qualify for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with this section.

History: En. Sec. 28, Ch. 596, L. 1993; amd. Sec. 28, Ch. 379, L. 1995; amd. Sec. 33, Ch. 370, L. 2015; amd. Sec. 16, Ch. 9, L. 2017; amd. Sec. 7, Ch. 60, L. 2019; amd. Sec. 1, Ch. 65, L. 2021.

33-2-1217. Reduction of liability for reinsurance ceded by domestic insurer to assuming insurer — definition. A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of 33-2-1216 must be allowed in an amount not exceeding the liabilities carried by the ceding insurer. The reduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(1) under a reinsurance contract with the assuming insurer as security for the payment of obligations under the contract if the security is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer; or

(2) in the case of a trust, in a qualified United States financial institution. This security may be in the form of:

(a) cash;

(b) securities listed by the securities valuation office of the NAIC, including those exempt from filing as defined in the purposes and procedures manual of the securities valuation office, and qualifying as admitted assets;

(c) clean, irrevocable, unconditional letters of credit that are issued or confirmed by a qualified United States financial institution no later than December 31 of the year for which filing is being made and that are in the possession of the ceding insurer on or before the filing date of the insurer's annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation must, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever occurs first.

(d) any other form of security acceptable to the commissioner.

(3) For the purposes of subsection (2)(c), a "qualified United States financial institution" means an institution that:

(a) is organized or, in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any of its states;

(b) is regulated, supervised, and examined by United States federal or state authorities with regulatory authority over banks and trust companies; and

(c) has been determined by either the commissioner or the securities valuation office of the national association of insurance commissioners to meet the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(4) For the purposes of this part, except for subsection (2)(c), "qualified United States financial institution" means, with respect to institutions eligible to act as a fiduciary of a trust, an institution that:

(a) is organized or, in the case of a United States branch or agency office of a foreign banking corporation, licensed under the laws of the United States or any of its states and that has been granted authority to operate with fiduciary powers; and

(b) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies.

(5) The commissioner may adopt rules implementing:

(a) the provisions of 33-2-307, 33-2-708, and chapter 12; and

(b) reinsurance arrangements provided under this section provided that:

(i) a rule adopted pursuant to this subsection (5)(b) may apply only to reinsurance relating to:

(A) life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(B) universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(C) variable annuities with guaranteed death or living benefits;

(D) long-term care insurance policies; or

(E) such other life and health insurance and annuity products as to which NAIC adopts model regulatory requirements with respect to credit for reinsurance;

(ii) a rule adopted pursuant to subsection (5)(b)(i)(A) or (5)(b)(i)(B) may apply to any treaty containing:

(A) policies issued on or after January 1, 2015; or

(B) policies issued prior to January 1, 2015, if risk pertaining to policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

History: En. Sec. 29, Ch. 596, L. 1993; amd. Sec. 29, Ch. 379, L. 1995; amd. Sec. 43, Ch. 304, L. 1999; amd. Sec. 34, Ch. 370, L. 2015; amd. Sec. 2, Ch. 65, L. 2021.

33-2-1218. Reinsurance agreements affected. Sections 33-2-1216 and 33-2-1217 apply to all cessions after October 1, 1993, under reinsurance agreements that have had an inception, anniversary, or renewal date on or after April 1, 1993.

History: En. Sec. 30, Ch. 596, L. 1993; amd. Sec. 30, Ch. 379, L. 1995.

Part 13
Supervision, Rehabilitation, and Liquidation

Part Cross-References

Notice to Attorney General — court action by state agency, 25-1-501.

33-2-1301. Short title. This part shall be cited as the "Insurers Supervision, Rehabilitation, and Liquidation Act".

History: En. Sec. 1, Ch. 383, L. 1979.

33-2-1302. Construction and purpose. (1) This part may not be interpreted to limit the powers granted the commissioner by other provisions of the law.

(2) This part shall be liberally construed to effect the purpose stated in subsection (3).

(3) The purpose of this part is the protection of the interests of insureds, claimants, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

(a) early detection of any potentially dangerous condition in an insurer and prompt application of appropriate corrective measures;

(b) improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

(c) enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(d) equitable apportionment of any unavoidable loss;

(e) lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process and by extending the scope of personal jurisdiction over debtors of the insurer outside this state; and

(f) regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

History: En. Sec. 1, Ch. 383, L. 1979.

33-2-1303. Definitions. For the purposes of this part the following definitions apply:

(1) "Ancillary state" means any state other than a domiciliary state.

(2) "Commissioner" means the commissioner of insurance of this state.

(3) "Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent.

(4) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing, or conserving the insurer and any summary proceeding under 33-2-1321 or 33-2-1322. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(5) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(a) the issuance or delivery of contracts of insurance to persons resident in this state;

(b) the solicitation of applications for contracts of insurance or other negotiations preliminary to the execution of the contracts;

(c) the collection of premiums, membership fees, assessments, or other consideration for contracts of insurance;

(d) the transaction of matters subsequent to execution of contracts of insurance and arising out of them; or

(e) operating as an insurer under a license or certificate of authority issued by the commissioner.

(6) "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry.

(7) "Fair consideration" is given for property or an obligation:

(a) when in exchange for the property or obligation, as a fair equivalent for the property or obligation and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(b) when the property or obligation is received in good faith to secure a present advance or antecedent debt in an amount not disproportionately small as compared to the value of the property or obligation obtained.

(8) "Foreign country" means any jurisdiction not in any state.

(9) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, must be treated as general assets.

(10) "Guaranty association" means the Montana insurance guaranty association, the workers' compensation security fund, the Montana life and health insurance guaranty association, and any other similar entity created by the legislature of this state for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities created by the legislature of any other state.

(11) (a) "Insolvency" or "insolvent" means:

(i) for an insurer issuing only assessable fire insurance policies, the inability to pay any obligation within 30 days after it becomes payable; or

(ii) for any other insurer, the inability to pay its obligations when they are due or when its admitted assets do not exceed its liabilities plus the greater of:

(A) any capital and surplus required by law for its organization; or

(B) the total par or stated value of its authorized and issued capital stock.

(b) For purposes of this subsection (11), "liabilities" include but are not limited to reserves required by statute or by the commissioner upon a subject company at the time of admission or subsequent to the time of admission.

(12) "Insurer" means any person who has done, purports to do, is doing, or is licensed to do insurance business and is or has been subject to the authority of or to liquidation, rehabilitation, reorganization, supervision, or conservation by any insurance commissioner. Any other persons included under 33-2-1304 are considered to be insurers.

(13) "Preferred claim" means any claim with respect to which the terms of this part accord priority of payment from the general assets of the insurer.

(14) "Receiver" means a receiver, liquidator, rehabilitator, or conservator as the context requires.

(15) "Reciprocal state" means any state other than this state in which in substance and effect 33-2-1342(1), 33-2-1381, 33-2-1382, and 33-2-1384 through 33-2-1386 are in force and in which provisions are in force requiring that the commissioner or equivalent official be the receiver of a delinquent insurer and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(16) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims that have become liens upon specific assets by reason of judicial process.

(17) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class of persons, but not including any claim secured by general assets.

(18) "State" means any state, district, or territory of the United States.

(19) "Transfer" includes the sale and every other mode, direct or indirect, of disposing of or parting with property or with an interest in the property or with the possession of the property or fixing a lien upon property or upon an interest in the property, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor is considered a transfer suffered by the debtor.

History: En. Sec. 2, Ch. 383, L. 1979; amd. Sec. 7, Ch. 169, L. 2013.

Cross-References

Assets and liabilities — reserves, Title 33, ch. 2, part 5.

Montana Insurance Guaranty Association, Title 33, ch. 10, part 1.

Montana Life and Health Insurance Guaranty Association Act, Title 33, ch. 10, part 2.

33-2-1304. To whom proceedings may be applied. The proceedings authorized by this part may be applied to:

(1) all insurers who are doing or have done insurance business in this state and against whom claims arising from that business may exist now or in the future;

(2) all insurers who purport to do an insurance business in this state;

(3) all insurers who have insureds resident in this state;

(4) all other persons organized or in the process of organizing with the intent to do an insurance business in this state;

(5) all nonprofit service plans, fraternal benefit societies and beneficial societies, health service corporations, and health maintenance organizations; and

(6) all title insurance companies.

History: En. Sec. 3, Ch. 383, L. 1979; amd. Sec. 9, Ch. 151, L. 2017.

33-2-1305. Who may bring action — procedure exclusive. (1) No delinquency proceeding may be commenced under this part by anyone other than the commissioner, and no court shall have jurisdiction to entertain, hear, or determine any proceeding commenced by any other person.

(2) No court of this state has jurisdiction to entertain, hear, or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation, or receivership of any insurer or praying for an injunction or restraining order or other relief preliminary to, incidental to, or relating to such proceedings other than in accordance with this part.

History: En. Sec. 4, Ch. 383, L. 1979.

33-2-1306. Personal jurisdiction. In addition to other grounds for jurisdiction provided by the law of this state, a court of this state having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Montana Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(1) if the person served is obligated to the insurer in any way as an incident to any agency or brokerage arrangement that may exist or has existed between the insurer and the insurance producer or broker in any action on or incident to the obligation;

(2) if the person served is a reinsurer who has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced or is an insurance producer or broker of or for the reinsurer in any action on or incident to the reinsurance contract; or

(3) if the person served is or has been an officer, manager, trustee, organizer, promoter, or person in a position of comparable authority or influence in an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced in any action resulting from such a relationship with the insurer.

History: En. Sec. 4, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989.

Cross-References

Service of process — Commissioner as attorney for service, Title 33, ch. 1, part 6.

33-2-1307. Stay pending out-of-state proceedings. If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

History: En. Sec. 4, Ch. 383, L. 1979.

33-2-1308. Venue. All actions herein authorized shall be brought in the district court in the county in which the office of the commissioner is located.

History: En. Sec. 4, Ch. 383, L. 1979.

Cross-References

Office of Commissioner — Lewis and Clark County, Art. III, sec. 2, Mont. Const.; Art. VI, sec. 1, Mont. Const.; 2-15-1902.

33-2-1309. Injunctions and orders. (1) Any receiver appointed in a proceeding under this part may at any time apply for and any court of general jurisdiction may grant such restraining orders, preliminary and permanent injunctions, and other orders as may be necessary to prevent:

(a) the transaction of further business;

(b) the transfer of property;

(c) interference with the receiver or with a proceeding under this part;

(d) waste of the insurer's assets;

(e) dissipation and transfer of bank accounts;

(f) the institution or further prosecution of any actions or proceedings;

(g) the obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets, or its policyholders;

(h) the levying of execution against the insurer, its assets, or its policyholders;

(i) the making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(j) the withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(k) any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders or the administration of any proceeding under this part.

(2) The receiver may apply to any court outside of the state for the relief described in subsection (1).

History: En. Sec. 5, Ch. 383, L. 1979.

Cross-References

Injunctions, Title 27, ch. 19.

33-2-1310. Cooperation of officers, owners, and employees. (1) An officer, manager, director, trustee, owner, employee, or insurance producer of any insurer or any other persons with authority over or in charge of any segment of the insurer's affairs shall cooperate with the commissioner in any proceeding under this part or any investigation preliminary to the proceeding.

(2) (a) The term "person" as used in this section includes any person who exercises control directly or indirectly over activities of an insurer through any holding company or other affiliate of the insurer.

(b) "To cooperate" includes but is not limited to the following:

(i) replying promptly in writing to any inquiry from the commissioner requesting a reply; and

(ii) making available to the commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in the insurer's possession, custody, or control.

(3) A person may not obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental to the proceeding.

(4) This section may not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings or other orders.

(5) Any person included within subsection (1) who fails to cooperate with the commissioner or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental to the proceeding or who violates any order the commissioner issued validly under this part may, after a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed $10,000 and to the revocation or suspension of any insurance licenses issued by the commissioner.

History: En. Sec. 6, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1098, Ch. 56, L. 2009; amd. Sec. 22, Ch. 396, L. 2017.

Cross-References

Appeals from Commissioner's decision, 33-1-711.

Misdemeanor, 45-2-101.

33-2-1311. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 7, Ch. 383, L. 1979.

33-2-1312 through 33-2-1320 reserved.

33-2-1321. Commissioner's summary orders and supervision proceedings. (1) If the commissioner determines, after a hearing held under subsection (5), that any domestic insurer has committed or engaged in or is about to commit or engage in any act, practice, or transaction that would subject it to delinquency proceedings under this part, the commissioner may make and serve upon the insurer and any other persons involved orders that are reasonably necessary to correct or eliminate the conduct.

(2) If upon examination or at any other time the commissioner determines that any domestic insurer is in a condition that renders the continuance of its business hazardous to the public or to holders of its policies or certificates of insurance or if the domestic insurer gives its consent, then the commissioner shall notify the insurer of the commissioner's determination and furnish to the insurer a written list of the commissioner's requirements to abate the determination.

(3) If the commissioner makes a determination to supervise an insurer subject to an order under subsection (1) or (2), the commissioner shall notify the insurer that it is under the supervision of the commissioner. During the period of supervision, the commissioner may appoint a supervisor to supervise the insurer. The order appointing a supervisor shall direct the supervisor to enforce orders issued under subsections (1) and (2) and may also require that the insurer may not do any of the following things during the period of supervision without the prior approval of the commissioner or the supervisor:

(a) dispose of, convey, or encumber any of its assets or its business in force;

(b) withdraw from any of its bank accounts;

(c) lend any of its funds;

(d) invest any of its funds;

(e) incur any debt, obligation, or liability;

(f) merge or consolidate with another company; or

(g) enter into any new reinsurance contract or treaty.

(4) Any insurer subject to an order under this section shall comply with the lawful requirements of the commissioner and, if placed under supervision, has 60 days from the date the supervision order is served within which to comply with the requirements of the commissioner. If the insurer fails to comply within that time, the commissioner may institute proceedings under 33-2-1331 or 33-2-1341 to have a rehabilitator or liquidator appointed or extend the period of supervision.

(5) The notice of hearing under subsection (1) and any order issued pursuant to subsection (1) must be served upon the insurer pursuant to the applicable rules of civil or administrative procedure. The notice of hearing must state the time and place of hearing and the conduct, condition, or ground upon which the commissioner would base an order. Unless mutually agreed between the commissioner and the insurer, the hearing must occur not less than 10 days or more than 30 days after notice is served and must be either in Lewis and Clark County or in some other place convenient to the parties to be designated by the commissioner. The commissioner shall hold all hearings under subsection (1) privately unless the insurer requests a public hearing, in which case the hearing must be public.

(6) (a) Any insurer subject to an order under subsection (2) may request a hearing to review that order. The hearing must be held as provided in subsection (5), but the request for a hearing may not stay the effect of the order.

(b) If the commissioner issues an order under subsection (2), the insurer may, at any time, waive a commissioner's hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies. Subsequent to a hearing, any party to the proceedings whose interests are substantially affected is entitled to judicial review of any order issued by the commissioner.

(7) During the period of supervision the insurer may request the commissioner to review an action taken or proposed to be taken by the supervisor, specifying the reason why the action complained of is believed not to be in the best interest of the insurer.

(8) If any person has violated any supervision order issued under this section that was still in effect for that person, the person is subject to a civil penalty imposed by the district court not to exceed $10,000.

(9) The commissioner may apply for and any court of general jurisdiction may grant restraining orders, preliminary and permanent injunctions, and other orders that may be necessary to enforce a supervision order.

(10) If any person subject to the provisions of this part, including any person described in 33-2-1310(1), knowingly violates any valid order of the commissioner issued under the provisions of this section and, as a result of the violation, the net worth of the insurer is reduced or the insurer suffers loss it would not otherwise have suffered, the person is personally liable to the insurer for the amount of any reduction or loss. The commissioner or supervisor is authorized to bring an action on behalf of the insurer in the district court to recover the amount of the reduction or loss together with any costs.

History: En. Sec. 9, Ch. 383, L. 1979; amd. Sec. 1099, Ch. 56, L. 2009.

Cross-References

Hearings and meetings of public agencies open to public, Art. II, sec. 9, Mont. Const.; Title 2, ch. 3, part 2.
Notice of hearing — administrative proceeding, 2-3-104, 2-4-601.
Judicial review of contested cases, Title 2, ch. 4, part 7.
Injunctions, Title 27, ch. 19.

33-2-1322. Court's seizure order. (1) The commissioner may file in a district court of this state a petition alleging, with respect to a domestic insurer:

(a) that there exist grounds that would justify a court order for a formal delinquency proceeding against an insurer under this part;

(b) that the interests of policyholders, creditors, or the public will be endangered by delay; and

(c) the contents of an order considered necessary by the commissioner.

(2) Upon a filing under subsection (1), the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer and of the premises occupied by it for transaction of its business and until further order of the court enjoin the insurer and its officers, managers, insurance producers, and employees from disposition of its property and from transaction of its business except with the written consent of the commissioner.

(3) The court shall specify in the order what its duration shall be, which shall be such time as the court considers necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it considers desirable after such notice as it considers appropriate and may extend,

shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this part after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this part shall ipso facto vacate the seizure order.

(4) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(5) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than 15 days after the request. A hearing under this subsection may be held privately in chambers, and it shall be so held if the insurer proceeded against so requests.

(6) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

History: En. Sec. 10, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989.

Cross-References

Injunctions, Title 27, ch. 19.

33-2-1323. Confidentiality of proceedings. In all proceedings and judicial reviews under 33-2-1321 and 33-2-1322, all records of the insurer, all other documents, and all files and court records and papers of the commissioner, as far as they pertain to or are a part of the record of the proceedings, remain confidential except as necessary to obtain compliance with the proceedings unless the district court, after hearing arguments from the parties in chambers, orders otherwise or unless the insurer requests that the matter be made public. Until the court order, all papers filed with the clerk of the district court must be held in a confidential file.

History: En. Sec. 11, Ch. 383, L. 1979; amd. Sec. 1100, Ch. 56, L. 2009; amd. Sec. 22, Ch. 19, L. 2011.

Cross-References

Deliberations of state agencies open to public, Art. II, sec. 9, Mont. Const.; 2-3-203.

Records of state agencies available for public examination, Art. II, sec. 9, Mont. Const.; 2-6-1003.

33-2-1324 through 33-2-1330 reserved.

33-2-1331. Grounds for rehabilitation. The commissioner may apply by petition to a district court for an order authorizing the commissioner to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(1) The insurer is in such condition that the further transaction of business would be financially hazardous to its policyholders, creditors, or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general insurance producer, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise and whether direct or indirect, is in a person found after notice and hearing to be untrustworthy.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general insurance producer, director or trustee, employee, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact the insurer has failed promptly and effectively to terminate the employment and status of the person and the person's influence on management.

(6) After demand by the commissioner under 33-1-408 or under this part, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records or those of any subsidiary or related company within the control of the insurer or those of any person having executive authority in the insurer so far as they pertain to the insurer.

(7) Without first obtaining the written consent of the commissioner, the insurer has transferred or attempted to transfer, in a manner contrary to chapter 2, part 11, or chapter 2, part 12, of Title 33, substantially its entire property or business or has entered into any transaction the effect of which is to merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator, or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and the appointment has been made or is imminent, and the appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this part.

(9) Within the previous 4 years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the commissioner under 33-2-1321.

(10) The insurer has failed to pay within 60 days after the due date any obligation to any state or any subdivision of the state or any judgment entered in any state, if the court in which the judgment was entered had jurisdiction over the subject matter, except that nonpayment may not be a ground until 60 days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to give an adequate explanation immediately.

(12) The board of directors or the holders of a majority of the shares entitled to vote request or consent to rehabilitation under this part.

History: En. Sec. 12, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 50, Ch. 596, L. 1993.

Cross-References

Fraud, 28-2-404 through 28-2-406.
Suspension or revocation of certificate of authority — special grounds, 33-2-119.
Theft, 45-6-301.
Defrauding creditors, 45-6-315.
Forgery, 45-6-325.

33-2-1332. Rehabilitation orders. (1) An order to rehabilitate the business of a domestic insurer or an alien insurer domiciled in this state shall appoint the commissioner the rehabilitator and shall direct the rehabilitator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The filing or recording of the order with the clerk of the district court or clerk and recorder of the county in which the principal business of the company is conducted or the county in which its principal office or place of business is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with the county clerk and recorder would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(2) Any order issued under this section shall require accounting to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in its order.

(3) Entry of an order of rehabilitation does not constitute an anticipatory breach of any contracts of the insurer.

History: En. Sec. 13, Ch. 383, L. 1979.

Cross-References

When delay or failure to perform or offer to perform excused, 28-1-1301.

33-2-1333. Powers and duties of the rehabilitator. (1) The commissioner as rehabilitator may appoint one or more special deputies, who have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ counsel, clerks, and assistants. The compensation of the special deputy, counsel, clerks, and assistants and all expenses of taking possession of the insurer and of conducting the proceedings must be fixed by the commissioner with the approval of the court and must be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner. If the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs incurred out of any appropriation for the maintenance of the commissioner's office. Any amounts advanced for expenses of administration must be repaid to the commissioner for the use of the commissioner's office out of the first available money of the insurer.

(2) The rehabilitator may take action as necessary to reform and revitalize the insurer. The rehabilitator shall have all the powers of the directors, officers, and managers, whose authority must be suspended, except as they are redelegated by the rehabilitator. The rehabilitator has full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(3) If it appears to the rehabilitator that there has been criminal or tortious conduct or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, insurance producer, broker, employee, or other person, the rehabilitator may pursue all appropriate legal remedies on behalf of the insurer.

(4) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger, or other transformation of the insurer is appropriate, the rehabilitator shall prepare a plan to effect the changes. Upon application of the rehabilitator for approval of the plan and after notice and hearings that the court may prescribe, the court may either approve or disapprove the plan proposed or may modify it and approve it as modified. Any plan approved under this section must be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies for the period and to the extent as may be necessary.

(5) The rehabilitator has the power under 33-2-1351 and 33-2-1352 to avoid fraudulent transfers.

History: **En. Sec. 14, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1101, Ch. 56, L. 2009.**

Cross-References

Liens — general provisions, Title 71, ch. 3, part 1.

33-2-1334. Effect of proceedings on pending and potential litigation. (1) Any court in this state before which any action or proceeding in which the insurer is a party or is obligated to defend a party is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for 90 days and an additional time that is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take action respecting the pending litigation that the rehabilitator considers necessary in the interests of justice and for the protection of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) A statute of limitations or defense of laches may not run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the order of rehabilitation is entered or the petition is denied.

History: **En. Sec. 15, Ch. 383, L. 1979; amd. Sec. 1102, Ch. 56, L. 2009.**

Cross-References

Statutes of limitation, Title 27, ch. 2.

33-2-1335. Standing of guaranty associations in proceedings. Any guaranty association or foreign guaranty association covering life or health insurance or annuities has standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

History: **En. Sec. 15, Ch. 383, L. 1979.**

Cross-References

Guaranty associations, Title 33, ch. 10.

33-2-1336. Termination of rehabilitation. (1) Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders, or the public or would be futile, the commissioner may petition the district court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under 33-2-1341. The district court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(2) The rehabilitator may at any time petition the district court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under 33-2-1331 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The district court may also make that finding and issue that order at any time upon its own motion.

History: **En. Sec. 16, Ch. 383, L. 1979.**

33-2-1337 through 33-2-1340 reserved.

33-2-1341. Grounds for liquidation. The commissioner may petition the district court for an order directing the commissioner to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

(1) of any ground for an order of rehabilitation as specified in 33-2-1331, whether or not there has been a prior order directing the rehabilitation of the insurer;

(2) that the insurer is insolvent; or

(3) that the insurer is in a condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors, or the public.

History: **En. Sec. 17, Ch. 383, L. 1979; amd. Sec. 1103, Ch. 56, L. 2009.**

33-2-1342. Liquidation orders. (1) An order to liquidate the business of a domestic insurer must appoint the commissioner and the commissioner's successors in office liquidator and shall direct the liquidator to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the clerk of the district court and the clerk and recorder of the county in which its principal office or place of business is located or, in the case of real estate, with the clerk and recorder of the county where the property is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that clerk and recorder would have imparted.

(2) Upon issuance of the order, the rights and liabilities of any insurer and of its creditors, policyholders, shareholders, members, and all other persons interested in its estate become fixed as of the date of entry of the order of liquidation, except as provided in 33-2-1343 and 33-2-1366.

(3) An order to liquidate the business of an alien insurer domiciled in this state must be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States are the only assets and business included in the order.

(4) At the time of petitioning for an order of liquidation or at any time after petitioning, the commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of insolvency. After providing notice and hearing as it considers proper, the court may make the declaration.

(5) Any order issued under this section must require accounting to the court by the liquidator. Accountings must be at intervals as the court specifies in its order.

(6) (a) Within 5 days after the initiation of an appeal of an order of liquidation that has not been stayed, the commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. The plan must provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation,

including the ground of insolvency. In the event that the defendant company's financial condition will not, in the judgment of the commissioner, support the full performance of all policy claims obligations during the appeal pendency period, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties, as well as other policyholders and claimants, as the commissioner finds to be fair and equitable, considering the relative circumstances of the policyholders and claimants. The court shall examine the plan submitted by the commissioner, and if it finds the plan to be in the best interests of the parties, the court shall approve the plan. An action does not lie against the commissioner or any of the commissioner's deputies, agents, clerks, assistants, or attorneys by any party based on preference in an appeal pendency plan approved by the court.

(b) The appeal pendency plan may not supersede or affect the obligations of any insurance guaranty association.

(c) A plan must provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, in the event that the liquidator pays claims from assets of the estate, which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, so that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. If an order of liquidation is set aside upon any appeal, the company may not be released from delinquency proceedings unless all funds advanced by any guaranty association, including reasonable administrative expenses that relate to obligations of the company, have been repaid in full, together with interest at the judgment rate of interest, or unless an arrangement for repayment has been made with the consent of all applicable guaranty associations.

History: **En. Sec. 18, Ch. 383, L. 1979; amd. Sec. 51, Ch. 596, L. 1993.**

33-2-1343. Continuance of policy coverage. (1) All policies, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(a) a period of 30 days from the date of entry of the liquidation orders;

(b) the expiration of the policy coverage;

(c) the date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or

(d) the liquidator has effected a transfer of the policy obligation pursuant to 33-2-1345(1)(h).

(2) An order of liquidation under 33-2-1342 terminates coverages at the time specified in subsection (1) for purposes of any other statute.

(3) Policies of life or health insurance or annuities continue in force for such period and under such terms as provided by any applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2).

History: **En. Sec. 19, Ch. 383, L. 1979.**

Cross-References

Guaranty associations, Title 33, ch. 10.

33-2-1344. Dissolution of insurer. The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time the commissioner applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it must be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

History: **En. Sec. 20, Ch. 383, L. 1979; amd. Sec. 1104, Ch. 56, L. 2009.**

33-2-1345. Powers of liquidator. (1) The liquidator may:

(a) appoint a special deputy to act for the liquidator under this part and determine the deputy's reasonable compensation. The special deputy has all powers of the liquidator granted by this section. The special deputy serves at the pleasure of the liquidator.

(b) employ insurance producers, legal counsel, actuaries, accountants, appraisers, consultants, and other personnel necessary to assist in the liquidation;

(c) fix the reasonable compensation of employees and insurance producers, legal counsel, actuaries, accountants, appraisers, and consultants with the approval of the court;

(d) pay reasonable compensation to persons appointed and defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. If the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs incurred out of any appropriation for the maintenance of the commissioner's office. Any amounts advanced for expenses of administration must be repaid to the commissioner for the use of the commissioner's office out of the first available money of the insurer.

(e) hold hearings, subpoena witnesses to compel their attendance, administer oaths, examine any person under oath, and compel any person to subscribe to the person's testimony after it has been correctly reduced to writing and in connection with the hearings require the production of any books, papers, records, or other documents that the liquidator considers relevant to the inquiry;

(f) collect all debts and money due and claims belonging to the insurer, wherever located, and for this purpose:

(i) institute timely action in other jurisdictions in order to forestall garnishment and attachment proceedings against the debts;

(ii) do other acts that are necessary to collect, conserve, or protect its assets or property, including selling, compounding, compromising, or assigning debts for collection purposes on terms and conditions that the liquidator considers best; and

(iii) pursue any creditor's remedies available to enforce the liquidator's claims;

(g) conduct public and private sales of the property of the insurer;

(h) use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer if the transfer can be arranged without prejudice to applicable priorities under 33-2-1371;

(i) acquire, encumber, lease, improve, sell, or transfer any property of the insurer at its market value or upon terms and conditions that are fair and reasonable. The liquidator also has the power to execute, acknowledge, and deliver any and all deeds, assignments, releases, and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

(j) borrow money on the security of the insurer's assets or without security and execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation;

(k) enter into contracts that are necessary to carry out the order to liquidate and affirm or disavow any contracts to which the insurer is a party;

(l) continue to prosecute and institute in the name of the insurer or in the liquidator's own name any and all suits and other legal proceedings, in this state or elsewhere, and abandon the prosecution of claims that the liquidator considers unprofitable to pursue further. If the insurer is dissolved under 33-2-1344, the liquidator has the power to apply to any court in this state or elsewhere for leave to substitute for the insurer as plaintiff.

(m) prosecute any action that may exist in behalf of the creditors, members, policyholders, or shareholders of the insurer against any officer of the insurer or any other person;

(n) remove any or all records and property of the insurer to the offices of the commissioner or to another place that may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations must have reasonable access to the records of the insurer that is necessary for them to carry out their statutory obligations.

(o) deposit in one or more banks in this state sums that are required for meeting current administration expenses and dividend distributions;

(p) invest all sums not currently needed, unless the court orders otherwise;

(q) file any necessary documents for record in the office of any county clerk and recorder in this state or elsewhere where property of the insurer is located;

(r) assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed may not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to the obligation and may defend only in the absence of a defense by the guaranty associations.

(s) exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder, or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with 33-2-1351 through 33-2-1357;

(t) intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee and act as the receiver or trustee whenever the appointment is offered;

(u) enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation, or dissolution of an insurer doing business in both states;

(v) exercise all powers now held or conferred upon receivers by the laws of this state not inconsistent with the provisions of this part.

(2) The enumeration in this section of the powers and authority of the liquidator may not be construed as a limitation upon the liquidator or exclude in any manner the right to do other acts not specifically enumerated or otherwise provided for that may be necessary for the accomplishment of or in aid of the purpose of liquidation.

History: **En. Sec. 21, Ch. 383, L. 1979; amd. Sec. 143, Ch. 575, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1105, Ch. 56, L. 2009.**

Cross-References

Statutes of limitation, Title 27, ch. 2.
Receivers — general provisions, Title 27, ch. 20, part 1.
Statute of frauds, 28-2-903.
Usury, 31-1-107, 31-1-108.
Guaranty associations, Title 33, ch. 10.

33-2-1346. Notice to creditors and others. (1) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(a) by first-class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is doing business;

(b) by first-class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(c) by first-class mail to all insurance producers of the insurer;

(d) by first-class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders, at their last-known address as indicated by the records of the insurer; and

(e) by publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in other locations that the liquidator considers appropriate.

(2) Notice to potential claimants under subsection (1) requires claimants to file with the liquidator their claims together with proper proofs of the claims under 33-2-1365, on or before a date the liquidator specifies in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants have a duty to keep the liquidator informed of any changes of address.

(3) (a) Notice under subsection (1) to insurance producers of the insurer and to potential claimants who are policyholders must include, when applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

(b) The liquidator shall promptly provide to the guaranty associations information concerning the identities and addresses of the policyholders and their policy coverages as is within the liquidator's possession or control and shall otherwise cooperate with guaranty associations to assist them in providing to the policyholders timely notice of the guaranty associations' coverage of policy benefits, including coverage of claims and continuation or termination of coverages.

(4) If notice is given in accordance with this section, the distribution of assets of the insurer under this part is conclusive with respect to all claimants, whether or not they received notice.

History: **En. Sec. 22, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 52, Ch. 596, L. 1993.**

33-2-1347. Duty of insurance producers to give notice. (1) Every person who receives notice in the form prescribed in 33-2-1346 that an insurer that the person represents as an insurance producer is the subject of a liquidation order shall within 15 days of the notice give notice of the liquidation order. The notice must be sent by first-class mail to the last address contained in the insurance producer's records to each policyholder or other person named in any policy issued through the insurance producer by the insurer if the producer has a record of the address of the policyholder or other person. A policy must be considered issued through an insurance producer if the insurance producer has a property interest in the expiration of the policy or if the insurance producer has had in the producer's possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another. The written notice must include the name and address of the insurer, the name and address of the insurance producer, identification of the policy impaired, and the nature of the impairment, including termination of coverage as described in 33-2-1343. Notice by a general insurance producer satisfies the notice requirement for any insurance producers under contract to the producer. Each insurance producer obligated to give notice under this section shall file a report of compliance with the liquidator.

(2) Any insurance producer failing to give notice or file a report of compliance as required in subsection (1) may be subject to payment of a penalty of not more than $1,000 and may have the producer's license suspended after a hearing held by the commissioner.

(3) The liquidator may waive the duties imposed by this section if the liquidator determines that other notice to the policyholders of the insurer under liquidation is adequate.

History: **En. Sec. 23, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1106, Ch. 56, L. 2009.**

Cross-References

Licenses — administrative proceedings, 2-4-631.
Hearings by Commissioner, 33-1-701.
Insurance producer's license — suspension, Title 33, ch. 17, part 10.

33-2-1348. Effect of proceedings on pending and potential litigation — actions by liquidator. (1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, an action at law or equity may not be brought against the insurer or liquidator, whether in this state or elsewhere. Any existing actions may not be maintained or further presented after issuance of the order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company when the injunctions are included in an order to liquidate an insurer issued pursuant to corresponding provisions in other states. Whenever in the liquidator's judgment protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, the liquidator may intervene in the action. The liquidator may defend any action in which the liquidator intervenes under this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation, within 2 years or a time in addition to 2 years that applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which the order is entered. When, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim or for filing any claim, proof of claim, proof of loss, demand, notice, or the like or when in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act and when in any case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any action or do any act required of or permitted to the insurer within a period of 180 days subsequent to the entry of an order for liquidation or within a further period that is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(3) A statute of limitations or defense of laches may not run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the

denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least 60 days after the petition is denied.

History: En. Sec. 24, Ch. 383, L. 1979; amd. Sec. 1107, Ch. 56, L. 2009.

Cross-References

Statutes of limitation, Title 27, ch. 2.

33-2-1349. Standing of guaranty associations in proceedings. Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

History: En. Sec. 24, Ch. 383, L. 1979.

Cross-References

Guaranty associations, Title 33, ch. 10.

33-2-1350. Collection and listing of assets. (1) As soon as practicable after the liquidation order but not later than 120 days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One copy shall be filed in the office of the clerk of the district court, and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(2) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(3) A submission to the court for disbursement of assets in accordance with 33-2-1363 fulfills the requirements of subsection (1) of this section.

History: En. Sec. 25, Ch. 383, L. 1979.

33-2-1351. Fraudulent transfers prior to petition. (1) Every transfer made or suffered and every obligation incurred by an insurer within 1 year prior to the filing of a successful petition for rehabilitation or liquidation under this part is fraudulent as to then existing and future creditors if made or incurred without fair consideration or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this part which is fraudulent under this section may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee who in good faith has given a consideration less than fair for such transfer, lien, or obligation may retain the property, lien, or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver succeeds to and may enforce the rights of the purchaser, lienor, or obligee.

(2) (a) A transfer of property other than real property is considered to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under 33-2-1353(3).

(b) A transfer of real property is considered to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien is not considered to be perfected if there are available means by which a legal lien could be created.

(d) Any transfer not perfected prior to the filing of a petition for liquidation is considered to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(3) Any transaction of the insurer with a reinsurer is considered fraudulent and may be avoided by the receiver under subsection (1) if:

(a) the transaction consists of the termination, adjustment, or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and

(b) any part of the transaction took place within 1 year prior to the date of filing of the petition through which the receivership was commenced.

History: **En. Sec. 26, Ch. 383, L. 1979.**

Cross-References

Fraudulent conveyances, Title 31, ch. 2, part 3; Title 70, ch. 20, part 4.

33-2-1352. Fraudulent transfer after petition. (1) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith is valid against the receiver if made for a present fair equivalent value or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid, for which amount the transferee must have a lien on the property transferred. The commencement of a proceeding in rehabilitation or liquidation is constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the county clerk and recorder in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state may not be impaired by the pendency of a rehabilitation or liquidation proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(2) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(a) a transfer of any of the property of the insurer, other than real property, made to a person acting in good faith is valid against the receiver if made for a present fair equivalent value or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid, for which amount the transferee must have a lien on the property transferred;

(b) a person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property or any part of the property to the insurer or upon the person's order, with the same effect as if the petition were not pending;

(c) a person having actual knowledge of the pending rehabilitation or liquidation is considered not acting in good faith;

(d) a person asserting the validity of a transfer under this section has the burden of proof. Except as otherwise provided in this section, a transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator is not valid against the liquidator.

(3) This part does not impair the negotiability of currency or negotiable instruments.

History: **En. Sec. 27, Ch. 383, L. 1979; amd. Sec. 1108, Ch. 56, L. 2009.**

Cross-References

Fraudulent conveyances, Title 31, ch. 2, part 3; Title 70, ch. 20, part 4.
Effect of recordation — real property, 70-21-302.

33-2-1353. Voidable preferences and liens. (1) (a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within 1 year before the filing of a successful petition for liquidation under this part, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then the transfers must be considered preferences if made or allowed within 1 year before the filing of the successful petition for rehabilitation or within 2 years before the filing of the successful petition for liquidation, whichever time is shorter.

(b) Any preference may be avoided by the liquidator if:

(i) the insurer was insolvent at the time of the transfer;

(ii) the transfer was made within 4 months before the filing of the petition;

(iii) the creditor receiving it or to be benefited by it or the creditor's agent acting with reference to the transfer had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(iv) the creditor receiving it was an officer or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer, whether or not the creditor held the position, or any shareholder holding directly or indirectly more than 5%

of any class of any equity security issued by the insurer or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(c) When the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except when a bona fide purchaser or lienor has given less than fair equivalent value, the purchaser or lienor has a lien upon the property to the extent of the consideration actually given by the purchaser or lienor. When a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title passes to the liquidator.

(2) (a) A transfer of property other than real property is considered to be made or allowed when it becomes so far perfected that a subsequent lien is not obtainable by legal or equitable proceedings on a simple contract that could become superior to the rights of the transferee.

(b) A transfer of real property is considered to be made or allowed when it becomes so far perfected that a subsequent bona fide purchaser from the insurer could not obtain rights superior to the rights of the transferee.

(c) A transfer that creates an equitable lien is not considered to be perfected if there are available means by which a legal lien could be created.

(d) A transfer not perfected prior to the filing of a petition for liquidation is considered to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(3) (a) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of the proceedings upon the entry or docketing of a judgment or decree or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens that under applicable law are given a special priority over other liens that are prior in time.

(b) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee or a purchaser could obtain rights superior to the rights of a transferee, within the meaning of subsection (2), if the consequences would follow only from the lien or purchase itself or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. However, a lien could not become superior and a purchase could not create superior rights for the purpose of subsection (2) through any acts subsequent to the obtaining of a lien or subsequent to a purchase that require the agreement or concurrence of any third party or that require any further judicial action or ruling.

(4) A transfer of property for or on account of a new and contemporaneous consideration that is considered under subsection (2) to be made or suffered after the transfer because of delay in perfecting it does not become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within 21 days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if a loan is actually made, or a transfer that becomes security for a future loan must have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(5) If any lien considered voidable under subsection (1)(b) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this part that results in a liquidation order, the indemnifying transfer or lien must also be considered voidable.

(6) The property affected by any lien considered voidable under subsections (1) and (5) must be discharged from the lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety must pass to the liquidator, except that the court may on due notice order any lien to be preserved for the benefit of the estate and the court may direct that the conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

History: **En. Sec. 28, Ch. 383, L. 1979; amd. Sec. 1109, Ch. 56, L. 2009.**

Cross-References
U.C.C. — secured transactions, Title 30, ch. 9A.
Fraudulent conveyances, Title 31, ch. 2, part 3; Title 70, ch. 20, part 4.
Priority of liens, 71-3-113.

33-2-1354. Procedure for voiding preferences and liens. (1) The district court has summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under 33-2-1353 through 33-2-1357. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. When an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien and, if the value is less than the amount for which the property is indemnity or less than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator within such reasonable times as the court shall fix.

(2) The liability of a surety under a releasing bond or other like obligation is discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator or, when the property is retained under subsection (1), to the extent of the amount paid to the liquidator.

History: En. Sec. 28, Ch. 383, L. 1979.

33-2-1355. Set off for further credit given in good faith. If a creditor has been preferred and afterward in good faith gives the insurer further credit without security of any kind for property that becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference that would otherwise be recoverable from the insurer.

History: En. Sec. 28, Ch. 383, L. 1979; amd. Sec. 1110, Ch. 56, L. 2009.

33-2-1356. Transactions to pay for attorneys' services. If an insurer, directly or indirectly, within 4 months before the filing of a successful petition for liquidation under this part or at any time in contemplation of a proceeding to liquidate it, pays money or transfers property to an attorney at law for services rendered or to be rendered, the transaction may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court and the excess may be recovered by the liquidator for the benefit of the estate, provided that where the attorney is in a position of influence in the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney at law for services rendered or to be rendered shall be governed by the provision of 33-2-1353(1)(b)(iv).

History: En. Sec. 28, Ch. 383, L. 1979.

33-2-1357. Personal liability. (1) Every officer, manager, employee, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when the individual has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference is personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is reasonable cause to so believe if the transfer was made within 4 months before the date of filing of a successful petition for liquidation.

(2) Every person receiving any property from the insurer or the benefit of the property as a preference voidable under 33-2-1353(1) is personally liable and is bound to account to the liquidator.

(3) This section does not prejudice any other claim by the liquidator against any person.

History: En. Sec. 28, Ch. 383, L. 1979; amd. Sec. 1111, Ch. 56, L. 2009.

33-2-1358. Claims of holders of void or voidable rights. (1) The claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment, or encumbrance voidable under this part may not be allowed unless the creditor surrenders the preference, lien, conveyance, transfer, assignment, or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim may not be allowed unless the money is paid or the property is delivered to the liquidator within 30 days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(2) A claim allowable under subsection (1) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance may be filed as an excused late filing under 33-2-1364 if filed within 30 days from the date of the avoidance or within the further time allowed by the court under subsection (1).

History: En. Sec. 29, Ch. 383, L. 1979; amd. Sec. 1112, Ch. 56, L. 2009.

33-2-1359. Setoffs. (1) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this part must be set off and the balance only allowed or paid, except as provided in 33-2-1362 and subsection (2) of this section.

(2) A setoff may not be allowed in favor of any person when:

(a) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(b) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff; or

(c) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer or is to pay a balance upon a subscription to the capital stock of the insurer or is in any other way in the nature of a capital contribution.

History: En. Sec. 30, Ch. 383, L. 1979; amd. Sec. 10, Ch. 531, L. 1997.

33-2-1360. Assessments against members of insurer. (1) As soon as practicable but not more than 2 years from the date of an order of liquidation under 33-2-1342 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(a) the reasonable value of the assets of the insurer;

(b) the insurer's probable total liabilities;

(c) the probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(d) a recommendation as to whether or not an assessment should be made and in what amount.

(2) (a) Upon the basis of the report provided for in subsection (1), including any supplements and amendments, the district court may levy one or more assessments against all members of the insurer who are subject to assessment.

(b) Subject to any applicable legal limits on assessability, the aggregate assessment must be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(3) After levy of assessment under subsection (2), the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment for the assessment.

(4) The liquidator shall give notice of the order to show cause by publication and by first-class mail to each member liable for the assessment mailed to the member's last-known address as it appears on the insurer's records at least 20 days before the return day of the order to show cause.

(5) (a) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (3), the court shall make an order adjudging the member liable for the amount of the assessment against the member, pursuant to subsection (3), together with costs, and the liquidator has a judgment against the member for that amount.

(b) If on or before the return day the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make an order that the facts warrant. If the commissioner determines that the objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(6) The liquidator may enforce any order or collect any judgment under subsection (5) by any lawful means.

History: En. Sec. 31, Ch. 383, L. 1979; amd. Sec. 1113, Ch. 56, L. 2009.

33-2-1361. Reinsurer's liability. The amount recoverable by the liquidator from reinsurers may not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor may not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

History: En. Sec. 32, Ch. 383, L. 1979.

33-2-1362. Recovery of premiums owed. (1) (a) An insurance producer or any other person responsible for the payment of a premium, other than the insured, is obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator may recover from the person any part of an unearned premium that represents a commission of the person. Credits or setoffs or both may not be allowed to an insurance producer for any amounts advanced to the insurer by the insurance producer on behalf of but in the absence of a payment by the insured.

(b) An insured shall pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

(2) Upon satisfactory evidence of a violation of this section, the commissioner may pursue either one or both of the following courses of action:

(a) suspend, revoke, or refuse to renew the licenses of any offending party;

(b) impose a penalty of not more than $1,000 for each act in violation of this section by the party.

(3) Before the commissioner may take any action as set forth in subsection (2), the commissioner shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation and fixing a time and place, at least 10 days after the notice, when a hearing on the matter will be held. After the hearing or upon failure of the accused to appear at the hearing, the commissioner, if a violation is found, shall impose penalties under subsection (2) that the commissioner considers advisable.

(4) When the commissioner takes action in any of the ways set out in subsection (2), the party aggrieved may appeal from the action to the district court.

History: En. Sec. 33, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1114, Ch. 56, L. 2009.

Cross-References

Licensure — administrative proceedings, 2-4-631.
Hearing before Commissioner, 33-1-701.
Appeals from Commissioner's decision, 33-1-711.
Suspension or revocation of insurance producer's license, Title 33, ch. 17, part 10.

33-2-1363. Domiciliary liquidator's proposal to distribute assets. (1) Within 120 days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall make application to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as assets become available, to a guaranty association or foreign guaranty association having obligations because of the insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section must be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) The proposal must at least include provisions for:

(a) reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in 33-2-1371, class 1;

(b) disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(c) equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled to a disbursement;

(d) the securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in 33-2-1371 in accordance with the priorities. A bond may not be required of the association.

(e) a full report to be made by each association to the liquidator accounting for all assets disbursed to the association, all disbursements made from the assets, any interest earned by the association on the assets, and any other matter that the court may direct;

(f) compliance with Title 33, chapter 3, part 6, if the insurer being liquidated is a domestic stock insurer or a domestic mutual insurer.

(3) The liquidator's proposal must provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made by the associations for which the associations could assert a claim against the liquidator and must provide that if the assets available for disbursement from time to time do not equal or exceed the amount of claim payments made or to be made by the association, then disbursements must be in the amount of available assets.

(4) The liquidator's proposal must, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming, or guaranteeing policies or contracts of insurance under the acts creating the associations.

(5) Notice of the application must be given to the association in each of the states and to the commissioners of insurance of each of the states. Any notice must be considered to have been given when deposited in the United States certified mail, first-class postage prepaid, at least 30 days prior to submission of the application to the court. Action on the application may be taken by the court if the required notice has been given and if the liquidator's proposal complies with subsections (2)(a) and (2)(b).

History: **En. Sec. 34, Ch. 383, L. 1979; amd. Sec. 26, Ch. 227, L. 2001; amd. Sec. 10, Ch. 151, L. 2017.**

Cross-References

Guaranty associations, Title 33, ch. 10.

33-2-1364. Filing of claims. (1) Proof of all claims must be filed with the liquidator in the form required by 33-2-1365 on or before the last day for filing specified in the notice required under 33-2-1346, except that proof of claims for cash surrender values or other investment values in life insurance and annuities is not required to be filed unless the liquidator requires.

(2) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if the claimant were not late, to the extent that any payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) the existence of the claim was not known to the claimant, and the claim was filed as promptly after learning of it as reasonably possible;

(b) a transfer to a creditor was avoided under 33-2-1351 through 33-2-1357 or was voluntarily surrendered under 33-2-1358, and the filing satisfies the conditions of 33-2-1358; and

(c) the valuation under 33-2-1370 of security held by a secured creditor shows a deficiency, which is filed within 30 days after the valuation.

(3) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late if the claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where the payments were made and expenses incurred as provided by law.

(4) The liquidator may consider any claim filed late that is not covered by subsection (2) and permit it to receive distributions that are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant must receive, at each distribution, the same percentage of the amount allowed on that claim that is being paid to claimants of any lower priority. This distribution must continue until the claim has been paid in full.

History: **En. Sec. 35, Ch. 383, L. 1979; amd. Sec. 1115, Ch. 56, L. 2009.**

33-2-1365. Proof of claim. (1) Proof of claim consists of a statement signed by the claimant that includes all of the following that are applicable:

(a) the particulars of the claim, including the consideration given for it;

(b) the identity and amount of the security on the claim;

(c) the payments made on the debt, if any;

(d) that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;

(e) any right of priority of payment or other specific right asserted by the claimants;

(f) a copy of the written instrument that is the foundation of the claim;

(g) the name and address of the claimant and the attorney who represents the claimant, if any.

(2) A claim is not required to be considered or allowed if it does not contain all the information in subsection (1) that may be applicable. The liquidator may require that a prescribed form be used and may require that other information and documents be included.

(3) At any time, the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (1) and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(4) A judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation and a judgment or order against an insured or the insurer entered at any time by default or by collusion are not required to be considered as evidence of liability or of quantum of damages. A judgment or order against an insured or the insurer entered within 4 months before the filing of the petition is not required to be considered as evidence of liability or of the quantum of damages.

(5) All claims of a guaranty association or foreign guaranty association must be in the form and contain the substantiation that may be agreed to by the association and the liquidator.

History: En. Sec. 36, Ch. 383, L. 1979; amd. Sec. 1116, Ch. 56, L. 2009.

33-2-1366. Special claims. (1) The claim of a third party that is contingent on the third party first obtaining a judgment against the insured must be considered and allowed as if there were no contingency.

(2) A claim may be allowed, even if contingent, if it is filed in accordance with 33-2-1364. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(3) Claims that are due except for the passage of time must be treated as absolute claims are treated, except that the claims may be discounted at the legal rate of interest.

(4) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under 33-2-1332 or 33-2-1342.

History: En. Sec. 37, Ch. 383, L. 1979; amd. Sec. 1117, Ch. 56, L. 2009.

Cross-References

Legal rate of interest, 31-1-106.

33-2-1367. Claims of insureds or claimants against insureds. (1) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(2) Whether or not the third party files a claim, the insured may file a claim on the insured's own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within 60 days after mailing of the notice required by 33-2-1346, whichever is later, the insured is an unexcused late filer.

(3) The liquidator shall make recommendations to the court under 33-2-1371 for the allowance of an insured's claim under subsection (2) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, the liquidator shall reconsider the claim on the bases of additional information and amend the recommendations to the court. The insured must be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it determines appropriate. As claims against the insured are settled or barred, the insured must be paid, from the amount withheld, the same percentage dividend as was paid on other claims of similar property, based on the lesser of the amount actually recovered from the

insured by action or paid by agreement, plus the reasonable costs and expenses of defense, or the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld must revert to the undistributed assets of the insurer. Delay in final payment under this subsection may not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(4) If several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed must be reduced in the same proportion so that the total equals the policy limit. Claims by the insured must be evaluated as provided in subsection (3). If any insured's claim is subsequently reduced under subsection (3), the amount freed must be apportioned ratably among the claims that have been reduced under this subsection.

(5) A claim may not be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

History: **En. Sec. 38, Ch. 383, L. 1979; amd. Sec. 1118, Ch. 56, L. 2009.**

Cross-References

Guaranty associations, Title 33, ch. 10.

33-2-1368. Disputed claims. (1) When a claim is denied in whole or in part by the liquidator, written notice of the determination must be given to the claimant or the claimant's attorney by first-class mail at the address shown in the proof of claim. Within 60 days from the mailing of the notice, the claimant may file objections with the liquidator. If a filing is not made, the claimant may not further object to the determination.

(2) Whenever objections are filed with the liquidator and the liquidator does not alter the denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first-class mail to the claimant or the claimant's attorney and to any other persons directly affected not less than 10 or more than 30 days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with a recommendation.

History: **En. Sec. 39, Ch. 383, L. 1979; amd. Sec. 1119, Ch. 56, L. 2009.**

33-2-1369. Claims of sureties. (1) Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person fails to prove and file that claim, the other person may do so in the creditor's name and must be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that the other person discharges the undertaking. However, in the absence of an agreement with the creditor to the contrary, the other person is not entitled to any distribution until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor must be held by the creditor in trust for the other person.

(2) The term "other person", as used in this section, is not intended to apply to a guaranty association or foreign guaranty association.

History: **En. Sec. 40, Ch. 383, L. 1979; amd. Sec. 1120, Ch. 56, L. 2009.**

Cross-References

When surety may require creditor to pursue remedy, 28-11-416.

Surety's right to reimbursement and contribution, 28-11-417.

33-2-1370. Claims of secured creditors. (1) The value of any security held by a secured creditor must be determined in one of the following ways, as the court may direct:

(a) by converting the security into money according to the terms of the agreement pursuant to which the security was delivered to the creditors; or

(b) by agreement, arbitration, compromise, or litigation between the creditor and the liquidator.

(2) The determination must be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount determined must be credited upon the secured claim, and any deficiency must be treated as an unsecured claim. If the claimant surrenders the claimant's security to the liquidator, the entire claim must be allowed as if unsecured.

History: **En. Sec. 41, Ch. 383, L. 1979; amd. Sec. 1121, Ch. 56, L. 2009.**

33-2-1371. Priority of distribution. The priority of distribution of claims from the insurer's estate is in accordance with the order in which each class of claims is set forth in this section. Every claim in each class must be paid in full or adequate funds retained for the payment before the members of the next class receive any payment. Subclasses may not be established within any class. The order of distribution of claims is as follows:

(1) Class 1—the costs and expenses of administration, including but not limited to the following:

(a) the actual and necessary costs of preserving or recovering the assets of the insurer;

(b) compensation for all services rendered in the liquidation;

(c) any necessary filing fees;

(d) the fees and mileage payable to witnesses;

(e) reasonable attorney fees;

(f) the reasonable expenses of a guaranty association or foreign guaranty association in handling claims.

(2) Class 2—all claims under policies for losses incurred, including third-party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies, and all claims of a guaranty association or foreign guaranty association for payment of covered claims or covered obligations of the insurer. All claims under life and health insurance and annuity policies, whether for death proceeds, health benefits, annuity proceeds, or investment values, must be treated as loss claims. The portion of any loss, indemnification that is provided by other benefits, or advantages recovered by the claimant may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance or as gratuities. A payment by an employer to an employee may not be treated as a gratuity.

(3) Class 3—claims of the federal government.

(4) Class 4—debts due to employees for services performed to the extent that they do not exceed $1,000 and represent payment for services performed within 1 year before the filing of the complaint for liquidation. Officers and directors may not be entitled to the benefit of this priority. The priority must be in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.

(5) Class 5—claims of general creditors.

(6) Class 6—claims of any state or local government. Claims, including those of any state or local government for a penalty or forfeiture, may be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, along with reasonable and actual costs. The remainder of the claims must be postponed to the class of claims under subsection (9).

(7) Class 7—claims filed late or any other claims other than claims under subsections (8) and (9).

(8) Class 8—surplus or contribution notes or similar obligations and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies are limited in accordance with law.

(9) Class 9—the claims of shareholders or other owners.

History: En. Sec. 42, Ch. 383, L. 1979; amd. Sec. 27, Ch. 227, L. 2001.

33-2-1372. Liquidator's recommendations to the court concerning claims. (1) The liquidator shall review all claims duly filed in the liquidation and make further investigation that the liquidator considers necessary. The liquidator may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court except when the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes must be determined under 33-2-1368. As soon as practicable, the liquidator shall present to the court a report of the claims against the insurer with the liquidator's recommendations. The report must include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(2) The court may approve, disapprove, or modify the report on claims by the liquidator. Reports not modified by the court within a period of 60 days following submission by the liquidator must be treated by the liquidator as allowed claims, subject to later modification or to rulings made by the court pursuant to 33-2-1368. A claim under a policy of insurance may not be allowed for an amount in excess of the applicable policy limits.

History: En. Sec. 43, Ch. 383, L. 1979; amd. Sec. 1122, Ch. 56, L. 2009.

33-2-1373. Distribution of assets. Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third-party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

History: En. Sec. 44, Ch. 383, L. 1979.

33-2-1374. Unclaimed and withheld funds. (1) All unclaimed funds subject to distribution remaining in the liquidator's hands when the liquidator is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member, or other person who is unknown or cannot be found, must be deposited with the state treasurer and must be paid without interest except in accordance with 33-2-1371 to the person entitled to the funds or the person's legal representative upon proof satisfactory to the state treasurer of the person's right to the funds. Any amount on deposit not claimed within 6 years from the discharge of the liquidator must be considered to have been abandoned and must be escheated without formal escheat proceedings and be deposited in the general fund.

(2) All funds withheld under 33-2-1366 and not distributed must upon discharge of the liquidator be deposited with the state treasurer and paid in accordance with 33-2-1371. Any sums remaining that under 33-2-1371 would revert to the undistributed assets of the insurer must be transferred to the state treasurer and become the property of the state under subsection (1) unless the commissioner petitions the court to reopen the liquidation under 33-2-1376.

History: En. Sec. 45, Ch. 383, L. 1979; amd. Sec. 1123, Ch. 56, L. 2009.

Cross-References

Escheated property — claims, Title 72, ch. 14.

33-2-1375. Termination of liquidation proceedings. (1) When all assets justifying the expense of collection and distribution have been collected and distributed under this part, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be considered appropriate.

(2) Any other person may apply to the court at any time for an order under subsection (1). If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

History: En. Sec. 46, Ch. 383, L. 1979.

33-2-1376. Reopening liquidation. After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the district court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

History: En. Sec. 47, Ch. 383, L. 1979.

33-2-1377. Disposition of records during and after liquidation. When it appears to the commissioner that the records of any insurer in the process of liquidation or completely liquidated are no longer useful, the commissioner may recommend to the court and the court shall direct which records should be retained for future reference and which should be destroyed.

History: En. Sec. 48, Ch. 383, L. 1979; amd. Sec. 1124, Ch. 56, L. 2009.

Cross-References

Public records management, Title 2, ch. 6, parts 10 and 11.

33-2-1378. Audit of the receiver's books. The district court may, as it considers desirable, cause audits to be made of the books of the commissioner relating to any receivership established under this part, and a report of each audit shall be filed with the commissioner and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

History: En. Sec. 49, Ch. 383, L. 1979.

33-2-1379. Conservation of property of foreign or alien insurers. (1) If a domiciliary liquidator has not been appointed, the commissioner may apply to the district court by verified petition for an order directing the commissioner to act as conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(a) any of the grounds in 33-2-1331;

(b) that any of its property has been sequestered by official action in its domiciliary state or in any other state;

(c) that enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent;

(d) that its certificate of authority to do business in this state has been revoked or that none was ever issued;

(e) that there are residents of this state with outstanding claims or outstanding policies.

(2) When an order is sought under subsection (1), the court shall cause the insurer to be given notice and a time to respond that is reasonable under the circumstances.

(3) The court may issue the order in whatever terms it considers appropriate. The filing or recording of the order with the clerk of the district court or the clerk and recorder of the county in which the principal business of the company is located or the county in which its principal office or place of business is located must impart the same notice as a deed, bill of sale, or other evidence of title filed or recorded with that clerk and recorder would have imparted.

(4) The conservator may at any time petition for and the court may grant an order under 33-2-1380 to liquidate assets of a foreign or alien insurer under conservation or, if appropriate, for an order under 33-2-1382 to be appointed ancillary receiver.

(5) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order the insurer to be restored to possession of its property and the control of its business. The court may also make a finding and issue an order at any time upon motion of any interested party, but if the motion is denied, all costs must be assessed against the party.

History: En. Sec. 50, Ch. 383, L. 1979; amd. Sec. 1125, Ch. 56, L. 2009.

33-2-1380. Liquidation of assets of foreign or alien insurers. (1) If a domiciliary receiver has not been appointed, the commissioner may apply to the district court by verified petition for an order directing the commissioner to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state on any of the following grounds:

(a) any of the grounds in 33-2-1331 or 33-2-1341; or

(b) any of the grounds specified in 33-2-1379(1)(b) through (1)(d).

(2) When an order is sought under subsection (1), the court shall cause the insurer to be given notice and time to respond that is reasonable under the circumstances.

(3) If it appears to the court that the best interests of creditors, policyholders, and the public require, the court may issue an order to liquidate in whatever terms it considers appropriate. The filing or recording of the order with the clerk of the district court or the clerk and recorder of the county in which the principal business of the company is located or the county in which its principal office or place of business is located shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that clerk and recorder would have imparted.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall act as ancillary receiver under 33-2-1382. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under 33-2-1382.

(5) On the same grounds as specified in subsection (1), the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the

insurer's assets and business over which the court will exercise jurisdiction or any lesser part of the assets and business that the commissioner considers desirable for the protection of the policyholders and creditors in this state.

(6) The court may order the commissioner, when the commissioner has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under rules that relate to the liquidation of insurers under this part and that are otherwise compatible with the provisions of this section.

History: En. Sec. 51, Ch. 383, L. 1979; amd. Sec. 1126, Ch. 56, L. 2009.

33-2-1381. Domiciliary liquidators in other states. (1) The domiciliary liquidator of an insurer domiciled in a reciprocal state is, except as to special deposits and security on secured claims under 33-2-1382(3), vested by operation of law with the title to all of the assets, property, contracts, and rights of action, insurance producers' balances, and all of the books, accounts, and other records of the insurer located in this state. The date of vesting must be the date of the filing of the petition if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting is the date of entry of the order directing possession to be taken. The domiciliary liquidator has the immediate right to recover balances due from insurance producers and to obtain possession of the books, accounts, and other records of the insurer located in this state. The domiciliary liquidator also has the right to recover all other assets of the insurer located in this state, subject to 33-2-1382.

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state is vested by operation of law with the title to all of the property, contracts, and rights of action and all of the books, accounts, and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under 33-2-1379 or 33-2-1380 or for an ancillary receivership under 33-2-1382 or, after approval by the district court, may transfer title to the domiciliary liquidator that the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

History: En. Sec. 52, Ch. 383, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1127, Ch. 56, L. 2009.

33-2-1382. Ancillary formal proceedings. (1) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the commissioner may file a petition with the district court requesting appointment as ancillary receiver in this state:

(a) if the commissioner finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver;

(b) if the protection of creditors or policyholders in this state requires.

(2) The court may issue an order appointing an ancillary receiver in whatever terms it considers appropriate. The filing or recording of the order with the county clerk and recorder imparts the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded.

(3) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from respective securities those special deposit claims and secured claims that are proved and allowed in the ancillary proceedings in this state and shall pay the necessary expenses of the proceedings. The ancillary receiver shall promptly transfer all remaining assets, books, accounts, and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and the ancillary receiver's deputies have the same powers and are subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(4) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties, and powers to those provided in subsection (3) for ancillary receivers appointed in this state.

History: **En. Sec. 53, Ch. 383, L. 1979; amd. Sec. 144, Ch. 575, L. 1981; amd. Sec. 1128, Ch. 56, L. 2009.**

Cross-References

Recorder of deeds — County Clerk and Recorder, 7-4-2619, 70-21-201.

33-2-1383. Ancillary summary proceedings. The commissioner may institute proceedings under 33-2-1321 through 33-2-1323 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

History: **En. Sec. 54, Ch. 383, L. 1979; amd. Sec. 1129, Ch. 56, L. 2009.**

33-2-1384. Claims of nonresidents against insurers domiciled in this state. (1) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this part or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in 33-2-1385(2) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states is conclusive as to amount and as to priority against special deposits or other security located in such ancillary states but is not conclusive with respect to priorities against general assets under 33-2-1371.

History: **En. Sec. 55, Ch. 383, L. 1979.**

33-2-1385. Claims of residents against insurers domiciled in reciprocal states. (1) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state or in ancillary proceedings, if any, in this state. If a claimant elects to prove a claim in this state, the claimant shall file the claim with the liquidator in the manner provided in 33-2-1364 and 33-2-1365. The ancillary receiver shall make a recommendation to the court in the same manner provided in 33-2-1372. The ancillary receiver shall also arrange a date for hearing, if necessary, under 33-2-1368 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service, at least 40 days prior to the date set for hearing. If the domiciliary liquidator, within 30 days after the giving of the notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of the ancillary receiver's intention to contest the claim, the ancillary receiver is entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state must be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

History: **En. Sec. 56, Ch. 383, L. 1979; amd. Sec. 1130, Ch. 56, L. 2009.**

Cross-References

Residence — rules for determining, 1-1-215.

33-2-1386. Exemption from legal process during pendency of liquidation. During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment, or levy of execution may be commenced or maintained in this state against the delinquent insurer or its assets.

History: **En. Sec. 57, Ch. 383, L. 1979.**

33-2-1387. Interstate priorities. (1) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state must control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states must be given equal priority of payment from general assets regardless of where the assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state is given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing must be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(3) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender the security and file the claim as a general creditor, or the claim may be discharged by resort to the security in accordance with 33-2-1370, in which case the deficiency, if any, must be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

History: En. Sec. 58, Ch. 383, L. 1979; amd. Sec. 1131, Ch. 56, L. 2009.

33-2-1388. Subordination of claims for noncooperation of ancillary receiver. If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within the ancillary receiver's control, other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, must be placed in the class of claims under 33-2-1371(8).

History: En. Sec. 59, Ch. 383, L. 1979; amd. Sec. 28, Ch. 227, L. 2001.

33-2-1389 and 33-2-1390 reserved.

33-2-1391. Condition on release from delinquency proceedings. An insurer that is subject to any delinquency proceeding, whether formal, informal, administrative, or judicial, may not:

(1) be released from the proceeding, unless the proceeding is converted to a judicial rehabilitation or liquidation proceeding;

(2) be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

(3) be returned to the control of its shareholders or private management; or

(4) have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses of the guaranty associations and interest on all payments and expenses, have been repaid to the guaranty associations or a plan of repayment by the insurer has been approved by the guaranty association.

History: En. Sec. 35, Ch. 596, L. 1993.

33-2-1392. Indemnification of rehabilitator, liquidator, and employees — persons covered. (1) The persons entitled to protection under 33-2-1393 and 33-2-1394 are:

(a) all rehabilitators and liquidators responsible for the conduct of a delinquency proceeding under Title 33, chapter 2, including present and former rehabilitators and liquidators; and

(b) the employees of the rehabilitators and liquidators, including all present and former special deputies and assistant special deputies appointed by the commissioner, and all persons whom the commissioner, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under Title 33, chapter 2.

(2) Attorneys, accountants, auditors, and other professional persons or firms, who are retained by the rehabilitator or liquidator as independent contractors, and their employees are not considered employees of the rehabilitator or liquidator for purposes of any cause of action initiated by the rehabilitator or liquidator against the independent contractor in the name of the rehabilitation or liquidation estate.

History: En. Sec. 36, Ch. 596, L. 1993.

33-2-1393. Indemnification of rehabilitator, liquidator, and employees. (1) If any legal action is commenced against the rehabilitator or liquidator or any employee of the rehabilitator or liquidator, whether against the rehabilitator, liquidator, or employee personally or in an official capacity, alleging property damage, property loss, personal injury, or other civil liability caused by or resulting from any alleged act, error, or omission of the rehabilitator, liquidator, or employee arising out of or by reason of duties or employment, the rehabilitator, liquidator, or employee is indemnified from the assets of the insurer for all expenses, attorney fees, judgments, settlements, decrees, surety bond premiums, or amounts due and owing or paid in satisfaction of or incurred in the defense of the legal action unless it is determined upon a final adjudication on the merits that the alleged act, error, or omission of the rehabilitator, liquidator, or employee that gave rise to the claim did not arise out of or by reason of the rehabilitator's, liquidator's, or employee's duties or employment or was caused by intentional or willful and wanton misconduct.

(2) Attorney fees and related expenses incurred in defending a legal action for which indemnity is available under this section must be paid from the assets of the insurer, as the expenses are incurred and in advance of the final disposition of the action, upon receipt of an undertaking by or on behalf of the rehabilitator, liquidator, or employee to repay the attorney fees and expenses. If, upon a final adjudication on the merits, it is determined that the rehabilitator, liquidator, or employee is not entitled to indemnity under this section, the payment must be made from the undertaking.

(3) An indemnification for expenses, attorney fees, judgments, settlements, decrees, surety bond premiums, or other amounts paid or to be paid from the insurer's assets pursuant to this section are an administrative expense of the insurer.

(4) If actual or threatened litigation against a rehabilitator, liquidator, or employee for which indemnity may be available under this section occurs, a reasonable amount of funds that in the judgment of the commissioner may be needed to provide indemnity must be segregated and reserved from the assets of the insurer as security for the payment of indemnity until all applicable statutes of limitation have run, all actual or threatened actions against the rehabilitator, liquidator, or employee have been completely and finally resolved, and all obligations of the insurer and the commissioner under this section have been satisfied.

(5) In lieu of segregation and reservation of funds, the commissioner may obtain a surety bond or make other arrangements that will enable the commissioner to fully secure the payment of all obligations under this section.

History: En. Sec. 37, Ch. 596, L. 1993.

33-2-1394. Settlement of actions against rehabilitator, liquidator, and employees — court approval — applicability. (1) If any legal action against an employee for which indemnity may be available under this section is settled prior to final adjudication on the merits, the insurer shall pay the settlement amount on behalf of the employee or indemnify the employee for the settlement amount unless the commissioner determines:

(a) that the claim did not arise out of or by reason of the employee's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the employee.

(2) In a legal action in which the rehabilitator or liquidator is a defendant, that portion of any settlement relating to the alleged act, error, or omission of the rehabilitator or liquidator is subject to the approval of the court before which the delinquency proceeding is pending. The court may not approve that portion of the settlement if it determines:

(a) that the claim did not arise out of or by reason of the rehabilitator's or liquidator's duties or employment; or

(b) that the claim was caused by the intentional or willful and wanton misconduct of the rehabilitator or liquidator.

(3) This section may not be construed to deprive the rehabilitator, liquidator, or employee of immunity, indemnity, benefit of law, right, or defense available under any provision of law, including, without limitation, the provisions of Title 2, chapter 9.

(4) (a) Except as otherwise provided, a legal action by a third party does not lie against the rehabilitator, liquidator, or employee based in whole or in part on any alleged act, error, or omission that took place prior to October 1, 1993, unless suit is filed and valid service of process is obtained by October 1, 1994. A legal action that is pending on or filed after September 30, 1993, by a liquidator or a liquidation estate will lie against a former special deputy liquidator or any employee, agent, or independent contractor retained by a special deputy liquidator without regard to when the alleged act, error, or omission occurred.

(b) Subsections (1) through (3) apply to any suit that is pending on or filed after October 1, 1993, without regard to when the alleged act, error, or omission took place.

History: **En. Sec. 38, Ch. 596, L. 1993; amd. Sec. 31, Ch. 379, L. 1995.**

Part 14
Certificates of Insurance Model Act

33-2-1401. Short title. This part may be cited as the "Certificates of Insurance Model Act".

History: **En. Sec. 1, Ch. 303, L. 2013.**

33-2-1402. Definitions. As used in this part, the following definitions apply:

(1) "Certificate of insurance" means a document or instrument, regardless of how titled or described, that is prepared or issued by an insurer or insurance producer as evidence of property or casualty insurance coverage. The term does not include a policy of insurance, insurance binder, policy endorsement, or automobile insurance identification or information card.

(2) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate property or casualty insurance.

(3) "Insurer" means an organization that issues property or casualty insurance.

(4) "Person" means an individual, partnership, corporation, association, or other legal entity, including any government or governmental subdivision or agency.

History: **En. Sec. 2, Ch. 303, L. 2013.**

33-2-1403. Certificate forms. (1) Except as provided in subsection (3), a person may not prepare, issue, request, or require the issuance of a certificate of insurance on property, operations, or risks located in this state unless the certificate of insurance form has been filed with the commissioner by or on behalf of an insurer.

(2) The commissioner shall prohibit the use of a certificate of insurance form if the form is unfair, misleading, or deceptive or violates public policy or law, including rules adopted by the commissioner.

(3) Insurers are not required to file the current standard certificate of insurance forms promulgated and filed with the commissioner by the association for cooperative operations research and development, the American association of insurance services, or the insurance services office, inc., or certificate of insurance forms whose specific content and wording are established by federal law or regulation or by any law or rule of this state.

(4) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively amend, extend, or alter the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance may not confer to any person new or additional rights beyond what the referenced policy of insurance expressly provides.

History: **En. Sec. 3, Ch. 303, L. 2013.**

33-2-1404. Limitations on use. (1) A person may not:

(a) alter or modify a certificate of insurance form filed with the commissioner;

(b) prepare, issue, request, or require the issuance of a certificate of insurance that contains any false or misleading information concerning the policy of insurance to which the certificate of insurance makes reference; or

(c) prepare, issue, request, or require the issuance of a certificate of insurance that purports to affirmatively or negatively alter, amend, or extend the coverage provided by the policy of insurance to which the certificate of insurance makes reference.

(2) A certificate of insurance may not warrant that the policy of insurance referenced in the certificate complies with the insurance or indemnification requirements of a contract, and the inclusion of a contract number or description in the certificate of insurance may not be interpreted as warranting compliance with the insurance or indemnification requirements of a contract.

History: **En. Sec. 4, Ch. 303, L. 2013.**

33-2-1405. Notice requirements. A person is entitled to notice of cancellation, nonrenewal, or other material change concerning a policy of insurance only if the person has notice rights under the terms of the policy of insurance or any endorsement to the policy. The terms and conditions of the notice are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.

History: **En. Sec. 5, Ch. 303, L. 2013.**

33-2-1406. Scope — voidness. (1) The provisions of this part apply to all certificates of insurance issued in connection with property, operations, or risks located in this state, regardless of where the policyholder, insurer, insurance producer, or person requesting or requiring the issuance of the certificate of insurance is located.

(2) A certificate of insurance or any other document or correspondence prepared, issued, requested, or required in violation of this part is void.

History: **En. Sec. 6, Ch. 303, L. 2013.**

33-2-1407. Enforcement and penalties — rulemaking. (1) The commissioner may examine and investigate the activities of any person that the commissioner reasonably believes has been or is engaged in an act or practice prohibited by this part.

(2) The commissioner may enforce the provisions of this part by issuing cease and desist orders and by imposing a fine not to exceed $1,000 for each violation.

(3) The commissioner may adopt rules to implement the provisions of this part.

History: **En. Sec. 7, Ch. 303, L. 2013.**

Part 15
Regulation of Controlled Insurers and Controlling Producers

33-2-1501. Definitions. As used in parts 15 through 17 of this chapter, the following definitions apply:

(1) "Accredited state" means a state in which the department of insurance or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the national association of insurance commissioners.

(2) "Actuary" means a person who is a member in good standing of the American academy of actuaries.

(3) "Captive insurer" means:

(a) an insurer that is owned by another entity and whose exclusive purpose is to insure risks of the parent entity and its affiliates; or

(b) in the case of a group or association, an insurer that is owned by the member insureds and whose exclusive purpose is to insure risks to member insureds and their affiliates.

(4) "Control" or "controlled" has the meaning defined in 33-2-1101.

(5) "Controlled insurer" means an authorized insurer that is controlled, directly or indirectly, by a producer.

(6) "Controlling person" means a person, firm, association, or corporation that has the power to direct or cause to be directed the management, control, or activities of a reinsurance intermediary.

(7) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(8) (a) "Insurer" means any person, firm, association, or corporation authorized, under Title 33, chapter 2, part 1, to transact insurance business in this state.

(b) The term does not mean:

(i) residual market pools and joint underwriting authorities or associations; or

(ii) captive insurers, other than captive risk retention groups as defined in 33-28-101.

(9) "Licensed producer" means a producer or reinsurance intermediary licensed pursuant to this title.

(10) (a) "Managing general agent" means a person who:

(i) manages all or part of the insurance business of an insurer and acts as an agent for the insurer;

(ii) either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross written premiums equal to or more than 5% of the policyholder surplus in any quarter or year; and

(iii) engages in one or more of the following activities on the business produced:

(A) adjustment or payment of claims in excess of an amount determined by the commissioner; or

(B) negotiation of reinsurance on behalf of the insurer.

(b) The term does not include:

(i) an employee of the insurer;

(ii) a manager of the United States branch of an alien insurer;

(iii) an underwriting manager who, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, is subject to Title 33, chapter 2, part 11, and whose compensation is not based solely on the value of premiums written;

(iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or an interinsurance exchange under powers of attorney;

(v) a person managing the property and liability business of a resident domestic farm mutual insurer who has been granted a managing general agent waiver under 33-4-320; or

(vi) a director of a resident domestic farm mutual insurer who adjusts claims and participates in the underwriting process.

(11) "NAIC" means the national association of insurance commissioners.

(12) "Producer" means an insurance producer or reinsurance intermediary authorized or licensed pursuant to this title.

(13) (a) "Qualified United States financial institution" means a financial institution that:

(i) is organized or licensed under the laws of the United States or any state;

(ii) is regulated, supervised, and examined by federal or state authorities having regulatory authority over banks and trust companies and that either:

(A) is determined by the commissioner to meet the standards of financial condition and standing considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit are acceptable to the commissioner; or

(B) is eligible to act as a fiduciary of a trust or has been granted authority to operate with fiduciary powers.

(b) For purposes of this definition, the commissioner may by rule adopt standards of financial condition and standing that may be developed from time to time by the securities valuation office of the NAIC.

(14) "Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

(15) "Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, who solicits, negotiates, or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the insurer.

(16) (a) "Reinsurance intermediary-manager" means a person who:

(i) has authority to bind or who manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department, or underwriting office; and

(ii) acts as an agent for the reinsurer, whether known as a reinsurance intermediary-manager, manager, or other similar term.

(b) The following persons are not considered reinsurance intermediary-managers with respect to the reinsurer:

(i) an employee of the reinsurer;

(ii) a manager of the United States branch of an alien reinsurer;

(iii) an underwriting manager who, pursuant to contract, manages all of the reinsurance operations of the reinsurer, is under common control with the reinsurer, is subject to Title 33, chapter 2, part 11, and whose compensation is not based on the volume of premiums written; or

(iv) a person who manages groups, associations, pools, or organizations of insurers that engage in joint underwriting or joint reinsurance and that are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

(17) "Reinsurer" means a person, firm, association, or corporation licensed in this state under this title as an insurer with authority to assume reinsurance.

(18) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

History: En. Sec. 1, Ch. 596, L. 1993; amd. Sec. 8, Ch. 227, L. 2011; amd. Sec. 2, Ch. 208, L. 2013; amd. Sec. 35, Ch. 370, L. 2015.

33-2-1502. Filing requirements. (1) Each domestic, foreign, and alien insurer authorized to transact insurance in this state shall, on or before March 1 of each year, file with the NAIC a copy of its annual statement convention form, along with any additional filings for the preceding year as prescribed by the commissioner. The information filed with the NAIC must be in the same format and scope as that required by the commissioner and must include the signed jurat page and the actuarial certification. Amendments to the annual statement filing that are subsequently filed with the commissioner must also be filed with the NAIC.

(2) Foreign insurers domiciled in a state that has a law substantially similar to this section are considered to be in compliance with this section.

History: En. Sec. 2, Ch. 596, L. 1993.

33-2-1503. Immunity of NAIC. In the absence of actual malice, members of the NAIC; their authorized committees, subcommittees, task forces, delegates, and employees; and all others charged with the responsibility of collecting and processing the information developed from the filing of the annual statement convention forms are considered to act under the authority of 33-2-1502 through 33-2-1504. They are not subject to civil liability for libel, slander, or any other cause of action arising from their collection, review, analysis, or dissemination of information collected from the filings required by 33-1-408 through 33-1-410, 33-2-1216 through 33-2-1218, 33-2-1391 through 33-2-1394, Title 33, chapter 2, parts 15 through 17, and 33-11-110.

History: En. Sec. 3, Ch. 596, L. 1993.

33-2-1504. Confidentiality. All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the NAIC insurance regulatory information systems are confidential and may not be disclosed by the department.

History: En. Sec. 4, Ch. 596, L. 1993.

33-2-1505 through 33-2-1508 reserved.

33-2-1509. Applicability of minimum standards. (1) The provisions of 33-2-1510 apply if, in any calendar year, the aggregate amount of gross written premiums on business placed with a controlled insurer by a controlling producer is equal to or greater than 5% of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year.

(2) Notwithstanding the provisions of subsection (1), the provisions of 33-2-1510 do not apply if:

(a) the controlling producer:

(i) does not receive compensation based upon the amount of premiums written in connection with the insurance and places insurance only with:

(A) the controlled insurer; or

(B) the controlled insurer and a member or members of the controlled insurer's holding company system or the controlled insurer's parent, affiliate, or subsidiary; and

(ii) accepts insurance placements only from nonaffiliated subproducers and not directly from insureds; and

(b) except for insurance business written through a residual market facility, the controlled insurer accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer, or a producer that is a subsidiary of the controlled insurer.

History: En. Sec. 5, Ch. 596, L. 1993.

33-2-1510. Minimum standards. Unless there is a written contract between a controlling producer and a controlled insurer specifying the responsibilities of each party, the controlled insurer may not accept business from the controlling producer and the controlling producer may not place business with the controlled insurer. The contract must be approved by the board of directors of the controlled insurer and must contain the following minimum provisions:

(1) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination.

(2) The controlling producer shall render to the controlled insurer accounts detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the controlling producer.

(3) On at least a monthly basis, the controlling producer shall remit to the controlled insurer all funds due under the terms of the contract. The due date must be fixed so that premiums or installments of premiums collected must be remitted no later than 90 days after the effective date of any policy placed with the controlled insurer under the contract.

(4) In accordance with the provisions of this title, all funds collected for the controlled insurer's account must be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the federal reserve system. However, funds of a controlling producer not required to be licensed in this state must be maintained in compliance with the requirements of the jurisdiction in which the controlling producer is domiciled.

(5) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer.

(6) The contract may not be assigned in whole or in part by the controlling producer.

(7) The controlled insurer shall provide the controlling producer with its underwriting standards, rules, procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates, and conditions. The standards, rules, procedures, rates, and conditions must be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer.

(8) The rates and terms of the controlling producer's commissions, charges, or other fees and the purposes of those commissions, charges, or fees must be contained in the contract. The rates of the controlling producer's commissions, charges, and other fees may not be greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of subsection (7) and this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits, and similar quality of business.

(9) If the contract provides that on insurance business placed with the controlled insurer, the controlling producer is to be compensated contingent upon the controlled insurer's profits on that business, then the compensation may not be determined and paid until at least 5 years after the premiums on liability insurance are earned and at least 1 year after the premiums are earned on any other insurance. The commissions may not be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to 33-2-1512.

(10) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings must be contained in the contract. The controlled insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and may not accept business from the controlling producer if the limit is reached. The controlling producer may not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached.

(11) The controlling producer may negotiate but may not bind reinsurance on behalf of the controlled insurer on business that the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines. For reinsurance assumed and ceded, the guidelines must include a list of reinsurers with which the automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules.

History: En. Sec. 6, Ch. 596, L. 1993; amd. Sec. 32, Ch. 379, L. 1995.

33-2-1511. Audit committee. Each controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually review the adequacy of the controlled insurer's loss reserves and meet with management, the controlled insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner.

History: En. Sec. 7, Ch. 596, L. 1993.

33-2-1512. Annual report by independent actuary. In addition to any other required loss reserve certification, the controlled insurer shall, on April 1 of each year, file with the commissioner an opinion of an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner. The opinion must report the loss ratios for each line of business written and must attest to the adequacy of loss reserves established for losses incurred and outstanding as of the yearend, including losses incurred but not reported, on business placed by the producer.

History: **En. Sec. 8, Ch. 596, L. 1993.**

33-2-1513. Annual report to commissioner. The controlled insurer shall annually report to the commissioner:

(1) the amount of commissions paid to the producer;

(2) the percentage the amount represents of the net premiums written; and

(3) comparable amounts and the percentage paid to noncontrolling producers for placements of the same kinds of insurance.

History: **En. Sec. 9, Ch. 596, L. 1993.**

33-2-1514. Disclosure. (1) Except as provided in subsection (2), the producer, prior to the effective date of the policy, shall deliver written notice to the prospective insured, disclosing the relationship between the producer and the controlled insurer.

(2) If the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in the controlling producer's records a signed commitment from the subproducer that the subproducer is aware of the relationship between the controlled insurer and the producer and that the subproducer has notified or will notify the insured.

History: **En. Sec. 10, Ch. 596, L. 1993.**

33-2-1515. Penalties. (1) (a) If the commissioner believes that a controlling producer or any other person has not materially complied with 33-2-1509 through 33-2-1514 or any regulation or order promulgated under 33-2-1509 through 33-2-1514, the commissioner, after notice and opportunity to be heard, may order the controlling producer to cease placing business with the controlled insurer.

(b) If it is found that because of the material noncompliance with 33-2-1509 through 33-2-1514, the controlled insurer or any policyholder of the controlled insurer has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the controlled insurer or policyholder for recovery of compensatory damages for the benefit of the controlled insurer or policyholder or other appropriate relief.

(2) The receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer if:

(a) an order for liquidation or rehabilitation of the controlled insurer has been entered pursuant to Title 33, chapter 2, part 13;

(b) the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with 33-2-1509 through 33-2-1514 or any regulation or order promulgated under 33-2-1509 through 33-2-1514; and

(c) the controlled insurer suffered any loss or damage from the noncompliance.

(3) This section does not affect the right of the commissioner to impose any other penalties provided for in this title.

(4) This section may not be construed to alter or affect the rights of policyholders, claimants, creditors, or other third parties.

History: **En. Sec. 11, Ch. 596, L. 1993.**

33-2-1516. Compliance — applicability. (1) Controlled insurers and controlling producers who are not in compliance with 33-2-1510 on October 1, 1993, have 60 days to come into compliance and shall comply with 33-2-1514 in all policies written or renewed on or after December 1, 1993.

(2) Sections 33-2-1509 through 33-2-1514 apply to insurers that are domiciled in this state or domiciled in a state that is not an accredited state that has in effect a substantially similar law.

(3) The provisions of Title 33, chapter 2, part 11, to the extent they are not superseded by 33-2-1509 through 33-2-1514, continue to apply to all entities within holding company systems subject to 33-2-1509 through 33-2-1514.

(4) An insurer may not continue to use the services of a managing general agent after December 1, 1993, unless the use complies with part 16 of this chapter.

(5) An insurer or reinsurer may not continue to use the services of a reinsurance intermediary after December 1, 1993, unless the use complies with part 17 of this chapter.

History: En. Sec. 12, Ch. 596, L. 1993.

33-2-1517. Rulemaking authority. (1) The commissioner may adopt rules implementing the provisions of 33-1-408 through 33-1-410, 33-2-1216 through 33-2-1218, 33-2-1391 through 33-2-1394, Title 33, chapter 2, parts 15 through 17, and 33-11-110.

(2) The authority of the commissioner to adopt rules is specifically extended, without limitation, to establish standards for companies considered to be in hazardous financial condition, to require annual audited financial reports, to regulate life and health reinsurance agreements, to provide for reports to the commissioner by holding company systems, and to establish accounting practices and procedures to be used by insurers in their annual statements.

History: En. Sec. 13, Ch. 596, L. 1993.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

Part 16
Regulation of Managing General Agents

Part Cross-References

Agency, Title 28, ch. 10.

33-2-1601. Licensure of managing general agent. (1) A person, firm, association, or corporation may not act in the capacity of a managing general agent with respect to risks located in this state for an insurer licensed in this state unless the person is a licensed producer in this state.

(2) A person, firm, association, or corporation may not act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless the person is licensed as a resident or nonresident producer in this state pursuant to the provisions of this part.

(3) The commissioner may require a bond in an amount acceptable to the commissioner for the protection of the insurer.

(4) The commissioner may require the managing general agent to maintain a policy on errors and omissions.

History: En. Sec. 14, Ch. 596, L. 1993.

33-2-1602. Managing general agent — required contract provisions. A person acting in the capacity of a managing general agent may not place business with an insurer unless there is in force a written contract between the parties that sets forth the responsibilities of each party. Whenever both parties share responsibility for a particular function, the written contract must specify the division of responsibilities. The contract must provide at least the following:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.

(2) The managing general agent shall render accounts to the insurer, detailing all transactions, and shall remit all funds due under the contract to the insurer on not less than a monthly basis.

(3) All funds collected for the account of an insurer must be held by the managing general agent in a fiduciary capacity in a bank that is a member of the federal reserve system. This account must be used for all payments on behalf of the insurer. The managing general agent may not retain more than 3 months' estimated claims payments and allocated loss adjustment expenses.

(4) Separate records of business written by the managing general agent must be maintained. The insurer has access to and may copy all accounts and records that are related to its business, in a form usable by the insurer. The commissioner has access to all books, bank accounts, and records of the managing general agent in a form usable to the commissioner. The records must be retained pursuant to 33-3-401.

(5) The contract may not be assigned in whole or in part by the managing general agent.

(6) The contract must contain appropriate underwriting guidelines, including:

(a) the maximum annual premium volume;

(b) the basis of the rates to be charged;

(c) the types of risks that may be written;

(d) maximum limits of liability;

(e) any applicable exclusions;

(f) the territorial limitations;

(g) policy cancellation provisions; and

(h) the maximum policy period.

(7) The insurer may cancel or decline to renew any policy of insurance, as provided by law.

(8) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(a) all claims must be reported to the company in a timely manner;

(b) a copy of the claims file must be sent to the insurer at its request or as soon as it becomes known that the claim:

(i) has the potential to exceed an amount determined by the commissioner or actually exceeds the limit set by the company, whichever is less;

(ii) involves a coverage dispute;

(iii) may exceed the managing general agent's claims settlement authority;

(iv) is open for more than 6 months; or

(v) is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less;

(c) all claims files are the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, the files become the sole property of the insurer or its estate. The managing general agent has reasonable access to and may copy the files on a timely basis.

(d) any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(9) When electronic claims files are in existence, the contract must address the timely transmission of the data.

(10) If the contract provides for a sharing of interim profits by the managing general agent and the managing general agent has the authority to determine the amount of the interim profits, whether by establishing loss reserves or controlling claim payments or in any other manner, interim profits may not be paid to the managing general agent until:

(a) 1 year after they are earned for property insurance business;

(b) 5 years after they are earned on casualty business; and

(c) the profits have been verified.

(11) The managing general agent may not:

(a) bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines, including for reinsurance assumed and ceded:

(i) a list of reinsurers with which automatic agreements are in effect;

(ii) the coverages and amounts or percentages that may be reinsured; and

(iii) commission schedules;

(b) commit the insurer to participate in insurance or reinsurance syndicates;

(c) appoint any producer without ensuring that the producer is lawfully licensed to transact the type of insurance for which the producer is appointed;

(d) without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which may not exceed 1% of the insurer's policyholder's surplus as of December 31 of the last-completed calendar year;

(e) collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without the prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer.

(f) permit its subproducer to serve on the insurer's board of directors;

(g) jointly employ an individual who is employed with the insurer; or

(h) appoint a submanaging general agent.

History: En. Sec. 15, Ch. 596, L. 1993.

33-2-1603. Duties of insurers. (1) The insurer must have on file an independent financial examination, in a form acceptable to the commissioner, of each managing general agent with which it has done business.

(2) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

(3) At least semiannually, the insurer shall conduct an onsite review of the underwriting and claims processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates rests with an officer of the insurer who is not affiliated with the managing general agent.

(5) Within 30 days of entering into or termination of a contract with a managing general agent, the insurer shall provide the commissioner with written notification of the appointment or termination. Notices of appointment of a managing general agent must include a statement of duties that the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

(6) An insurer shall review its books and records each quarter to determine if any producer has become a managing general agent. If the insurer determines that a producer has become a managing general agent, the insurer shall promptly notify the producer and the commissioner of the determination and the insurer and the producer shall comply with this part within 30 days.

(7) An insurer may not appoint to its board of directors an officer, director, employee, subproducer, or controlling shareholder of its managing general agent. This subsection does not apply to relationships governed by Title 33, chapter 2, part 11, or 33-2-1509 through 33-2-1514.

History: En. Sec. 16, Ch. 596, L. 1993.

33-2-1604. Examination authority. The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

History: En. Sec. 17, Ch. 596, L. 1993.

33-2-1605. Penalties and liabilities. (1) If, after a hearing conducted in accordance with Title 33, chapter 1, part 7, the commissioner finds that a person has violated any provision of this part, the commissioner may order:

(a) a penalty in an amount of $5,000 for each separate violation;

(b) revocation or suspension of the producer's license; and

(c) the managing general agent to reimburse the insurer, the rehabilitator, or a liquidator of the insurer for any losses incurred by the insurer caused by a violation of this part committed by the managing general agent.

(2) An order of the commissioner pursuant to subsection (1) is subject to judicial review pursuant to 33-1-711.

(3) This section does not limit the power of the commissioner to impose any other penalty provided in this title.

(4) This part does not limit the rights of policyholders, claimants, or creditors.

History: En. Sec. 18, Ch. 596, L. 1993; amd. Sec. 33, Ch. 379, L. 1995.

Part 17
Regulation of Reinsurance Intermediaries

33-2-1701. Licensure of reinsurance intermediaries. (1) A person, firm, association, or corporation may not act as a reinsurance intermediary-broker in this state if the reinsurance intermediary-broker maintains an office directly, as a member or employee of a firm or association, or as an officer, director, or employee of a corporation:

(a) in this state, unless the reinsurance intermediary-broker is a licensed producer in this state; or

(b) in another state, unless the reinsurance intermediary-broker is a licensed producer in this state or another state that has a law substantially similar to this law or unless the reinsurance intermediary-broker is licensed in this state as a nonresident reinsurance intermediary.

(2) A person, firm, association, or corporation may not act as a reinsurance intermediary-manager:

(a) for a reinsurer domiciled in this state, unless the reinsurance intermediary-manager is a licensed producer in this state;

(b) in this state, if the reinsurance intermediary-manager maintains an office either directly or as a member or employee of a firm or association or as an officer, director, or employee of a corporation in this state, unless the reinsurance intermediary-manager is a licensed producer in this state; or

(c) in another state for a nondomestic insurer, unless the reinsurance intermediary-manager is a licensed producer in this state or another state that has a law substantially similar to this law or unless the person is licensed in this state as a nonresident insurance intermediary.

(3) Subject to subsection (2), the commissioner may require a reinsurance intermediary-manager to:

(a) file a bond in an amount from an insurer acceptable to the commissioner for the protection of the reinsurer; and

(b) maintain a policy on errors and omissions in an amount acceptable to the commissioner.

(4) (a) The commissioner may issue a reinsurance intermediary license to any person, firm, association, or corporation that has complied with the requirements of this part. A license issued to a firm or association authorizes all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license. All authorized persons must be named in the application and in any supplements to the application. A license issued to a corporation must authorize all of the officers and any designated employees and directors to act as reinsurance intermediaries on behalf of the corporation. All authorized persons must be named in the application and in any supplements to the application.

(b) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall appoint an agent for service of process in the manner provided for by 33-1-605. The licensee shall promptly notify the commissioner in writing of each change in its appointed agent for service of process, and the change may not become effective until acknowledged by the commissioner.

(5) (a) The commissioner may refuse to issue a reinsurance intermediary license if, in the commissioner's judgment:

(i) the applicant, a person named on the application, or a member, principal, officer, or director of the applicant is not trustworthy;

(ii) a controlling person of the applicant is not trustworthy to act as a reinsurance intermediary; or

(iii) any of the persons listed in subsection (5)(a)(i) or (5)(a)(ii) has given cause for revocation or suspension of the license or has failed to comply with any prerequisite for the issuance of the license.

(b) Upon written request, the commissioner shall furnish a summary of the basis for refusal to issue a license.

(6) Licensed attorneys of this state, when acting in their professional capacity, are exempt from this section.

History: En. Sec. 19, Ch. 596, L. 1993; amd. Sec. 8, Ch. 416, L. 1999; amd. Sec. 8, Ch. 60, L. 2019.

33-2-1702. Required contract provisions — reinsurance intermediary-brokers. Transactions between a reinsurance intermediary-broker and the insurer it represents must be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization must, at a minimum, contain the following provisions:

(1) The insurer may terminate the reinsurance intermediary-broker's authority at any time.

(2) The reinsurance intermediary-broker shall render to the insurer accounts accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owing to the reinsurance intermediary-broker. The reinsurance intermediary-broker shall remit all funds due to the insurer within 30 days of receipt.

(3) All funds collected for the insurer's account must be held by the reinsurance intermediary-broker in a fiduciary capacity in a bank that is a qualified United States financial institution.

(4) The reinsurance intermediary-broker shall comply with the requirements of 33-2-1703.

(5) The reinsurance intermediary-broker shall comply with the written standards established by the insurer for the cession or retrocession of all risks.

(6) The reinsurance intermediary-broker shall disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

History: **En. Sec. 20, Ch. 596, L. 1993.**

33-2-1703. Books and records — reinsurance intermediary-brokers. (1) For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-broker, the reinsurance intermediary-broker shall keep a complete record for each transaction, showing:

(a) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(b) the period of coverage, including the effective and expiration dates, cancellation provisions, and notice required for cancellation;

(c) the reporting and settlement requirements of balances;

(d) the rate used to compute the reinsurance premium;

(e) the names and addresses of assuming reinsurers;

(f) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-broker;

(g) any related correspondence and memorandums;

(h) the proof of placement;

(i) the details regarding retrocessions handled by the reinsurance intermediary-broker, including the identity of the party making the retrocession and the percentage of each contract assumed or ceded;

(j) the financial records, including but not limited to premium and loss accounts; and

(k) when the reinsurance intermediary-broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(2) The insurer has access to and may copy and audit all accounts and records maintained by the reinsurance intermediary-broker that are related to the insurer's business, in a form usable by the insurer.

History: **En. Sec. 21, Ch. 596, L. 1993.**

33-2-1704. Duties of insurers utilizing the services of a reinsurance intermediary-broker. (1) An insurer may not engage the services of any person, firm, association, or corporation to act as a reinsurance intermediary-broker on its behalf unless the person is licensed as required by 33-2-1701.

(2) An insurer may not employ an individual who is employed by a reinsurance intermediary-broker with which it transacts business unless the reinsurance intermediary-broker is under common control with the insurer and is subject to the provisions of Title 33, chapter 2, part 11.

(3) The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-broker with which it transacts business.

History: **En. Sec. 22, Ch. 596, L. 1993.**

33-2-1705. Required contract provisions — reinsurance intermediary-managers. Transactions between a reinsurance intermediary-manager and the reinsurer it represents in that capacity may only be entered into pursuant to a written contract specifying the responsibilities of each party. The contract must be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through a producer, a true copy of the approved contract must be filed with the commissioner for approval. The contract must, at a minimum, include the following provisions:

(1) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary-manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

(2) The reinsurance intermediary-manager shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges, and other fees received by or owed to the reinsurance intermediary-manager, and shall remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(3) All funds collected for the reinsurer's account will be held by the reinsurance intermediary-manager in a fiduciary capacity in a bank that is a qualified United States financial institution. The reinsurance intermediary-manager may not retain more than 3 months' estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.

(4) For at least 10 years after expiration of each contract of reinsurance transacted by the reinsurance intermediary-manager, the reinsurance intermediary-manager shall keep a complete record for each transaction showing:

(a) the type of contract, limits, underwriting restrictions, classes or risks, and territory;

(b) the period of coverage, including effective and expiration dates, cancellation provisions, notice required for cancellation, and disposition of outstanding reserves on covered risks;

(c) the reporting and settlement requirements of balances;

(d) the rate used to compute the reinsurance premium;

(e) the names and addresses of reinsurers;

(f) the rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary-manager;

(g) related correspondence and memorandums;

(h) proof of placement;

(i) details regarding retrocessions handled by the reinsurance intermediary-manager, as permitted by 33-2-1707, including the identity of persons making the retrocessions and the percentage of each contract assumed or ceded;

(j) financial records, including but not limited to premium and loss accounts; and

(k) when the reinsurance intermediary-manager places a reinsurance contract on behalf of a ceding insurer:

(i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) if placed through a representative of the assuming reinsurer, other than an employee, written evidence that the assuming reinsurer has delegated binding authority to the representative.

(5) The reinsurer will have access to and the right to copy all accounts and records maintained by the reinsurance intermediary-manager related to its business in a form usable by the reinsurer.

(6) The contract may not be assigned in whole or in part by the reinsurance intermediary-manager.

(7) The reinsurance intermediary-manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection, or cession of all risks.

(8) The rates, terms, and purposes of commissions, charges, and other fees that the reinsurance intermediary-manager may levy against the reinsurer must be set forth.

(9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf of the reinsurer:

(a) all claims must be reported to the reinsurer in a timely manner;

(b) a copy of the claim file must be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(i) has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(ii) involves a coverage dispute;

(iii) may exceed the reinsurance intermediary-manager's claims settlement authority;

(iv) is open for more than 6 months; or

(v) is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer;

(c) all claim files must be the joint property of the reinsurer and the reinsurance intermediary-manager. However, upon an order of liquidation of the reinsurer, the files become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager must have reasonable access to and the right to copy the files on a timely basis.

(d) any settlement authority granted to the reinsurance intermediary-manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(10) If the contract provides for a sharing of interim profits by the reinsurance intermediary-manager, the interim profits may not be paid until:

(a) 1 year after the end of each underwriting period for property business;

(b) 5 years after the end of each underwriting period for casualty business;

(c) a later period set by the commissioner for specified lines of insurance; and

(d) the adequacy of reserves on remaining claims has been verified pursuant to 33-2-1707.

(11) The reinsurance intermediary-manager shall annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(12) The reinsurer shall, at least semiannually, conduct an onsite review of the underwriting and claims processing operations of the reinsurance intermediary-manager.

(13) The reinsurance intermediary-manager shall disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to the contract.

(14) Within the scope of its actual or apparent authority, the acts of the reinsurance intermediary-manager are considered to be the acts of the reinsurer on whose behalf it is acting.

History: En. Sec. 23, Ch. 596, L. 1993.

33-2-1706. Prohibited acts. A reinsurance intermediary-manager may not:

(1) bind retrocessions on behalf of the reinsurer, except that the reinsurance intermediary-manager may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for retrocessions. The guidelines must include a list of reinsurers with which automatic agreements are in effect and, for each reinsurer, must include the coverages, amounts of percentages that may be reinsured, and commission schedules.

(2) commit the reinsurer to participate in reinsurance syndicates;

(3) appoint any producer without ensuring that the producer is licensed to transact the type of reinsurance for which the producer is appointed;

(4) without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or 1% of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year;

(5) collect any payment from a party making a retrocession, or commit the reinsurer to any claim settlement with a party making a retrocession, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(6) jointly employ an individual who is employed by the reinsurer unless the reinsurance intermediary-manager is under common control with the reinsurer subject to Title 33, chapter 2, part 11;

(7) appoint a subreinsurance intermediary-manager.

History: **En. Sec. 24, Ch. 596, L. 1993.**

33-2-1707. Duties of reinsurers using services of reinsurance intermediary-manager. (1) A reinsurer may not engage the services of any person, firm, association, or corporation as a reinsurance intermediary-manager on its behalf unless the person is licensed as required by 33-2-1701.

(2) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary-manager that the reinsurer has engaged, prepared by an independent certified accountant, in a form acceptable to the commissioner.

(3) If a reinsurance intermediary-manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary-manager. The opinion is in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates must rest with an officer of the reinsurer who may not be affiliated with the reinsurance intermediary-manager.

(5) Within 30 days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of the termination to the commissioner.

(6) A reinsurer may not appoint to its board of directors any officer, director, employee, controlling shareholder, or subproducer of its reinsurance intermediary-manager. This subsection does not apply to relationships governed by Title 33, chapter 2, part 11, or, if applicable, 33-2-1701 through 33-2-1705.

History: **En. Sec. 25, Ch. 596, L. 1993.**

33-2-1708. Examination authority. (1) A reinsurance intermediary is subject to examination by the commissioner. The commissioner must have access to all books, bank accounts, and records of the reinsurance intermediary in a form usable to the commissioner.

(2) A reinsurance intermediary-manager may be examined as if it were the reinsurer.

History: **En. Sec. 26, Ch. 596, L. 1993.**

33-2-1709. Penalties and liabilities. (1) (a) A reinsurance intermediary, insurer, or reinsurer found by the commissioner, after a hearing conducted in accordance with Title 33, chapter 1, part 7, to be in violation of any provision of 33-2-1701 through 33-2-1708:

(i) shall, for each separate violation, pay a penalty in an amount not to exceed $5,000; and

(ii) is subject to revocation or suspension of its license.

(b) If a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator, or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

(2) The order of the commissioner pursuant to subsection (1) is subject to judicial review pursuant to Title 33, chapter 1, part 7.

(3) This section does not limit the authority of the commissioner to impose any other penalties provided in the insurance law.

(4) Sections 33-2-1701 through 33-2-1708 do not limit or restrict the rights of policyholders, claimants, creditors, or other third parties or confer any rights upon those persons.

History: **En. Sec. 27, Ch. 596, L. 1993.**

Part 18 reserved

Part 19
Risk-Based Capital for Insurers

33-2-1901. Short title. This part constitutes and may be referred to as "The Risk-Based Capital for Insurers Act".

History: **En. Sec. 82, Ch. 379, L. 1995.**

33-2-1902. Definitions. As used in this part, the following definitions apply:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with 33-2-1903(6).

(2) "Corrective order" means an order issued by the commissioner specifying corrective actions that the commissioner has determined are required.

(3) "Domestic insurer" means any insurance company or health organization domiciled in this state.

(4) "Foreign insurer" means any insurance company licensed to do business in this state under 33-2-116 but not domiciled in this state, or a health organization licensed to do business in this state under Title 33, chapter 31, but not domiciled in this state.

(5) "Health organization" means a health maintenance organization or other managed care organization licensed under Title 33, chapter 31. The term does not include an organization licensed as either a life or disability insurer or a property and casualty insurer, or that is otherwise subject to either the life and health or the property and casualty RBC requirements.

(6) "Insurer" includes life or other disability insurers, property and casualty insurers, and health organizations.

(7) "Life or disability insurer" means:

(a) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of disability insurance, as described in 33-1-207, or life insurance, as described in 33-1-208;

(b) a licensed property and casualty insurer writing only disability insurance;

(c) any insurer engaged solely in the business of reinsurance of life or disability contracts;

(d) a fraternal benefit society formed under Title 33, chapter 7; or

(e) a health service corporation formed under Title 33, chapter 30.

(8) "NAIC" means the national association of insurance commissioners.

(9) "Negative trend" means, with respect to a life or health insurer, a negative trend over a period of time, as determined in accordance with the trend test calculation included in the RBC instructions.

(10) (a) "Property and casualty insurer" means:

(i) any insurance company licensed under 33-2-116 and engaged in the business of entering into contracts of property insurance, as described in 33-1-210, or casualty insurance, as described in 33-1-206;

(ii) any insurance company engaged solely in the business of reinsurance of property and casualty contracts; or

(iii) any insurance company engaged in the business of surety and marine insurance.

(b) The term does not include monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers.

(11) "RBC instructions" means the RBC report, including risk-based capital instructions adopted by the NAIC, as the RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(12) "RBC level" means an insurer's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC, in which:

(a) "authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) (i) "company action level RBC" means, with respect to any insurer except the state fund as provided in subsection (12)(b)(ii), the product of 2 and its authorized control level RBC;

(ii) "company action level RBC" for the state fund is the product of 4 and its authorized control level RBC;

(c) "mandatory control level RBC" means the product of 0.70 and the authorized control level RBC; and

(d) (i) "regulatory action level RBC" means, except for the state fund as provided in subsection (12)(d)(ii), the product of 1.5 and its authorized control level RBC;

(ii) "regulatory action level RBC" for the state fund is the product of 3 and its authorized control level RBC.

(13) "RBC plan" means a comprehensive financial plan containing the elements specified in 33-2-1904(2). If the commissioner rejects the RBC plan and it is revised by the insurer, with or without the commissioner's recommendation, the plan must be called a revised RBC plan.

(14) "RBC report" means the report required in 33-2-1903.

(15) "Total adjusted capital" means the sum of:

(a) an insurer's statutory capital and surplus; and

(b) other items, if any, as the RBC instructions may provide.

History: En. Sec. 83, Ch. 379, L. 1995; amd. Sec. 11, Ch. 531, L. 1997; amd. Sec. 9, Ch. 63, L. 2015; amd. Sec. 6, Ch. 320, L. 2015; amd. Sec. 17, Ch. 9, L. 2017.

33-2-1903. RBC reports. (1) Each domestic insurer shall, on or before each March 1 filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the previous calendar year in a form and containing information as required by the RBC instructions. In addition, each domestic insurer shall file its RBC report:

(a) with the NAIC in accordance with the RBC instructions; and

(b) with the insurance commissioner in any state in which the insurer is authorized to do business if that insurance commissioner has notified the insurer of the request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) the March 1 filing date.

(2) A life and disability insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as are set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(3) A property and casualty insurer's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may be adjusted for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(4) A health organization's RBC must be determined in accordance with the formula set forth in the RBC instructions. The formula must take into account and may be adjusted for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and other relevant risks set forth in the RBC instructions and determined in each case by applying the factors in the manner set forth in the RBC instructions.

(5) An excess of capital over the amount produced by the risk-based capital requirements contained in this part and the formulas, schedules, and instructions referenced in 33-2-1906 through 33-2-1913 is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this part. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in or affecting the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this part.

(6) If a domestic insurer files an RBC report that in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice must contain a statement of the reason for the adjustment. An RBC report adjusted as provided in this subsection is referred to as an adjusted RBC report.

History: En. Sec. 84, Ch. 379, L. 1995; amd. Sec. 1, Ch. 28, L. 2009; amd. Sec. 9, Ch. 227, L. 2011; amd. Sec. 18, Ch. 9, L. 2017.

33-2-1904. Company action level event. (1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer indicating that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) for a life or disability insurer, the insurer has total adjusted capital that:

(A) is greater than or equal to its company action level RBC but less than its authorized control level RBC multiplied by 3; and

(B) has a negative trend;

(iii) for a property and casualty insurer, the insurer has total adjusted capital that:

(A) is greater than or equal to its company action level RBC but less than its authorized control level RBC multiplied by 3; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the RBC instructions; or

(iv) for a health organization, the insurer has total adjusted capital that:

(A) is greater than or equal to its company action level RBC but less than its authorized control level RBC multiplied by 3; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under 33-2-1908 or if the commissioner has rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that must:

(a) identify the conditions that contribute to the company action level event;

(b) contain proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event;

(c) provide projections of the insurer's financial results in the current year and at least the next 4 years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(d) identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) identify the quality of and problems associated with the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(3) The RBC plan must be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer challenges an adjusted RBC report pursuant to 33-2-1908, within 45 days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within 60 days after an insurer submits an RBC plan to the commissioner, the commissioner shall notify the insurer as to whether the RBC plan may be implemented or is unsatisfactory in the judgment of the commissioner. If the commissioner determines that the RBC plan is unsatisfactory, the notification to the insurer must set forth the reasons for the determination and may propose revisions intended to render the RBC plan satisfactory in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) within 45 days after the notification from the commissioner; or

(b) if the insurer challenges the notification from the commissioner under 33-2-1908, within 45 days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) If the commissioner notifies an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may, at the commissioner's discretion, subject to the insurer's right to a hearing under 33-2-1908, specify in the notification that the notification constitutes a regulatory action level event.

(6) Each domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) the state has an RBC provision substantially similar to 33-2-1909(1); and

(b) the insurance commissioner of that state has notified the insurer in writing of its request for the filing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under subsections (3) and (4).

History: En. Sec. 85, Ch. 379, L. 1995; amd. Sec. 10, Ch. 227, L. 2011; amd. Sec. 10, Ch. 63, L. 2015; amd. Sec. 19, Ch. 9, L. 2017.

33-2-1905. Regulatory action level event. (1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) the notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under 33-2-1908 or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to file an RBC report by the filing date, unless the insurer has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within 10 days after the filing date;

(d) the failure of the insurer to submit an RBC plan to the commissioner within the time period set forth in 33-2-1904(3);

(e) notification by the commissioner to the insurer that:

(i) the RBC plan or revised RBC plan submitted by the insurer is unsatisfactory in the judgment of the commissioner; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer if the insurer has not challenged the determination under 33-2-1908;

(f) if, pursuant to 33-2-1908, the insurer challenges a determination by the commissioner, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge;

(g) notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification and if the insurer has not challenged the determination under 33-2-1908 or the commissioner has not rejected the insurer's challenge.

(2) In the event of a regulatory action level event, the commissioner shall:

(a) require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) perform an examination or analysis as the commissioner considers necessary of the assets, liabilities, and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) subsequent to the examination or analysis, issue a corrective order specifying corrective actions that the commissioner determines are required.

(3) In determining corrective actions, the commissioner may take into account factors considered relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer, including but not limited to the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan must be submitted:

(a) within 45 days after the occurrence of the regulatory action level event;

(b) if the insurer challenges an adjusted RBC report pursuant to 33-2-1908 and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(c) if the insurer challenges a revised RBC plan pursuant to 33-2-1908 and the challenge is not frivolous in the judgment of the commissioner, within 45 days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants that may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, to examine or analyze the assets, liabilities, and operations of the insurer, and to formulate the corrective order with respect to the insurer. The fees, costs, and expenses relating to consultants must be borne by the affected insurer or such other party as directed by the commissioner.

History: En. Sec. 86, Ch. 379, L. 1995.

33-2-1906. Authorized control level event. (1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under 33-2-1908 or the commissioner rejects the insurer's challenge;

(c) the failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order if the insurer has not challenged the corrective order under 33-2-1908; or

(d) if the insurer has challenged a corrective order under 33-2-1908 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(a) take the actions required under 33-2-1905 regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) if the commissioner considers it to be in the best interests of the policyholders and creditors of the insurer and of the public, take the actions necessary to cause the insurer to be placed under regulatory control under Title 33, chapter 2, part 13. In the event that the commissioner places the insurer under regulatory control, the authorized control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. In the event that the commissioner takes an action under this subsection pursuant to an adjusted RBC report, the insurer is entitled to the protections afforded to insurers under the provisions of 33-2-1321 through 33-2-1323 pertaining to summary proceedings.

History: En. Sec. 87, Ch. 379, L. 1995.

33-2-1907. Mandatory control level event. (1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

(b) notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subsection (1)(a) if the insurer does not challenge the adjusted RBC report under 33-2-1908 or the commissioner rejects the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) with respect to a life or disability insurer or a health organization, the commissioner shall take the actions that are necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13. In that event, the mandatory control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds that there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

(b) with respect to a property and casualty insurer, the commissioner shall take the actions necessary to place the insurer under regulatory control under Title 33, chapter 2, part 13, or, in the case of an insurer that is not writing business and that is running-off its existing business, may allow the insurer to continue its runoff under the supervision of the commissioner. In either event, the mandatory control level event must be considered sufficient grounds for the commissioner to take action under Title 33, chapter 2, part 13, and the commissioner shall have the rights, powers, and duties with respect to the insurer as are set forth in Title 33, chapter 2, part 13. If the commissioner takes an action pursuant to an adjusted RBC report, the insurer is entitled to the protections of 33-2-1321 through 33-2-1323 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

History: En. Sec. 88, Ch. 379, L. 1995; amd. Sec. 20, Ch. 9, L. 2017.

33-2-1908. Notification and hearing. (1) An insurer has the right to a hearing before the department upon notification by the commissioner:

(a) of an adjusted RBC report or unsatisfactory RBC plan or revised RBC plan that constitutes a regulatory action level event with respect to the insurer;

(b) that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(c) of a corrective order with respect to the insurer.

(2) The insurer shall notify the commissioner of its request for a hearing within 5 days after the notification by the commissioner under subsection (1). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which may not be less than 10 or more than 30 days after the date of the insurer's request.

History: En. Sec. 89, Ch. 379, L. 1995.

Cross-References

Contested cases, Title 2, ch. 4, part 6.

33-2-1909. Confidentiality — prohibition on announcements — prohibition on use in ratemaking. (1) With respect to a domestic insurer or a foreign insurer, all RBC reports, to the extent the information in the reports is not required to be set forth in a publicly available annual statement schedule, and all RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant to this part and any corrective order issued by the commissioner pursuant to the examination or analysis, that are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors and must be kept confidential by the commissioner. This information may not be made public and is not subject to subpoena other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this part or any other provision of the insurance laws of this state.

(2) It is the intent of the legislature that the comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and that it is not intended as a means to rank insurers generally. Except as otherwise required under the provisions of 33-2-1911 through 33-2-1913, the making, publishing, disseminating, circulating, or placing before the public or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, in the form of a notice, circular, pamphlet, letter, or poster, over any radio or television station, or in any other way,

an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or of any component derived in the calculation that is by any insurer, producer, or other person engaged in any manner in the insurance business would be misleading and is prohibited. However, if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the insurer's RBC levels is published in any written publication and the insurer is able to demonstrate to the commissioner, with substantial proof, the falsity of the statement or the inappropriateness, as the case may be, the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) It is the further intent of the legislature that the RBC instructions, RBC reports, adjusted RBC reports, RBC plans, and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and may not be used by the commissioner for ratemaking or considered or introduced as evidence in any rate proceeding or used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer or any affiliate is authorized to write.

History: En. Sec. 90, Ch. 379, L. 1995.

33-2-1910. Supplemental provisions — rules — exemption. (1) The provisions of this part are supplemental to any other provisions of the laws of this state and do not preclude or limit any other powers or duties of the commissioner under the law, including but not limited to Title 33, chapter 2, part 13.

(2) The commissioner may adopt reasonable rules necessary for the implementation of this part.

(3) The commissioner may exempt from the application of this part any domestic property and casualty insurer that:

(a) writes direct business only in this state;

(b) writes direct annual premiums of $2 million or less; and

(c) does not assume reinsurance in excess of 5% of direct premium written.

(4) The commissioner may exempt from the application of this part any domestic health organization that:

(a) writes direct business only in this state;

(b) assumes no reinsurance in excess of 5% of direct premium written;

(c) writes direct annual premiums for comprehensive medical business of $1 million or less; and

(d) is a limited health service organization that covers fewer than 1,000 lives.

History: En. Sec. 91, Ch. 379, L. 1995; amd. Sec. 21, Ch. 9, L. 2017.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-2-1911. Foreign insurers. (1) A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report for the previous calendar year on the later of:

(a) the date that an RBC report would be required to be filed by a domestic insurer under 33-2-1903; or

(b) 15 days after the request is received by the foreign insurer.

(2) A foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(3) In the event of a company action level event, regulatory action level event, or authorized control level event, with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer or, if an RBC statute is not in force in that state, under the provisions of this part, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute or, if an RBC statute is not in force in that state, under 33-2-1904, the commissioner may require the foreign insurer to file an RBC plan with the commissioner.

In that event, the failure of the foreign insurer to file an RBC plan with the commissioner is grounds to order the insurer to cease and desist from writing new insurance business in this state.

(4) In the event of a mandatory control level event with respect to any foreign insurer, if a domiciliary receiver has not been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to a district court of this state permitted under 33-2-1380 with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event must be considered adequate grounds for the application.

History: En. Sec. 92, Ch. 379, L. 1995.

33-2-1912. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 93, Ch. 379, L. 1995.

33-2-1913. Notices. All notices by the commissioner to an insurer that may result in regulatory action are effective on dispatch if transmitted by certified mail or, in the case of any other transmission, are effective on the insurer's receipt of the notice.

History: En. Sec. 94, Ch. 379, L. 1995.

Part 20
Pharmacy Audit Integrity Act

33-2-2001. Short title. This part may be cited as the "Pharmacy Audit Integrity Act".

History: En. Sec. 1, Ch. 114, L. 2013.

33-2-2002. Definitions. As used in this part, the following definitions apply:

(1) "Audit" means a review of the records of a pharmacy by or on behalf of an entity that finances or reimburses the cost of health care services or pharmaceutical products.

(2) "Entity" includes:

(a) a pharmacy benefits manager;

(b) a health benefit plan;

(c) a third-party administrator; and

(d) a company, group, or agent that represents or is engaged by one of the entities described in this subsection (2).

(3) "Fraud" means an intentional act of deception, misrepresentation, or concealment in order to gain something of value.

(4) "Health benefit plan" means a policy or certificate that provides health care insurance or major medical expense insurance or that is offered as a substitute for hospital or medical expense insurance. The term does not include a policy or certificate that provides benefits solely for accident, dental, vision, income replacement, long-term care, a medicare supplement, a specified disease, or a short-term limited duration or that is offered and marketed as supplemental health insurance.

History: En. Sec. 2, Ch. 114, L. 2013.

33-2-2003. Applicability. (1) Except as provided in subsection (2), this part applies to an audit of the records of a pharmacy licensed under Title 37, chapter 7.

(2) This part does not apply to an audit of pharmacy records when fraud or other intentional and willful misrepresentation is evidenced by the review of claims data, statements, physical review, or other investigative methods.

History: En. Sec. 3, Ch. 114, L. 2013.

33-2-2004. Audit of pharmacy records. (1) An entity conducting an audit of pharmacy records shall audit a pharmacy using the same standards and parameters as used by the entity in auditing other pharmacies on behalf of the same audit client.

(2) An audit that involves clinical or professional judgment must be conducted by or in consultation with a licensed pharmacist who is employed by or working with the entity conducting the audit.

(3) If an audit is conducted onsite at a pharmacy, the entity conducting the audit:

(a) shall give the pharmacy 10 days' advance written notice of the audit, along with the range of prescription numbers or a date range that will be included in the audit; and

(b) may not audit the pharmacy during the first 5 business days of the month unless the pharmacy agrees to the timing of the audit.

(4) An entity may not audit prescription records that exceed 275 selected prescriptions. The period covered by the audit may not exceed 24 months from the date that the prescription was submitted to or adjudicated by the entity unless a longer period is required under state or federal law.

(5) Except as required by state or federal law, an entity conducting an audit may have access to a pharmacy's previous audit report only if the previous report was prepared by that entity.

(6) To validate a pharmacy record, a pharmacy may use documented statements of records in the pharmacy or pharmacy system, including medication administration records of a nursing home, assisted living facility, hospital, physician, surgeon, or other prescriber authorized by the laws of this state.

(7) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy to produce additional claims documentation using any commercially reasonable method, including fax, mail, or e-mail.

History: **En. Sec. 4, Ch. 114, L. 2013.**

33-2-2005. *(Temporary)* **Prohibitions — recoupment — payment — interest.** An entity conducting an audit may not:

(1) include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a dispensing error by the pharmacy, or the identified overpayment is based solely on an extra dispensing fee;

(2) recoup funds for prescription clerical or recordkeeping errors, including typographical errors, scrivener's errors, and computer errors, in a required document or record unless the error results in actual financial harm to the entity or to a consumer;

(3) collect any funds, charge-backs, or penalties until the audit and all appeals are final unless the entity is alleging fraud or other intentional or willful misrepresentation that is evidenced by the review of claims data, statements, physical review, or other investigative methods;

(4) use extrapolation or other statistical expansion techniques in calculating the amount of any recoupment or penalty;

(5) pay the agent or employee who conducted the audit based on a percentage of the amount recovered;

(6) charge interest during the audit period; or

(7) recoup funds on the basis of the timing of purchases of dispensed medication but instead shall permit a pharmacy to use drug purchase records without limitation of date or source to validate the dispensing of legend or narcotic drugs so long as the purchase of the drug was done in accordance with state or federal law. *(Terminates June 30, 2029—sec. 8, Ch. 474, L. 2025.)*

33-2-2005. *(Effective July 1, 2029)* **Prohibitions — recoupment — payment — interest.** An entity conducting an audit may not:

(1) include dispensing fees unless a prescription was not actually dispensed, the prescriber denied authorization, the prescription dispensed was a dispensing error by the pharmacy, or the identified overpayment is based solely on an extra dispensing fee;

(2) recoup funds for prescription clerical or recordkeeping errors, including typographical errors, scrivener's errors, and computer errors, in a required document or record unless the error results in actual financial harm to the entity or to a consumer;

(3) collect any funds, charge-backs, or penalties until the audit and all appeals are final unless the entity is alleging fraud or other intentional or willful misrepresentation that is evidenced by the review of claims data, statements, physical review, or other investigative methods;

(4) use extrapolation or other statistical expansion techniques in calculating the amount of any recoupment or penalty;

(5) pay the agent or employee who conducted the audit based on a percentage of the amount recovered; or

(6) charge interest during the audit period.

History: En. Sec. 5, Ch. 114, L. 2013; amd. Sec. 1, Ch. 474, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 1, Ch. 474, L. 2025. Amendment effective October 1, 2025, and terminates June 30, 2029.

Applicability: Section 7, Ch. 474, L. 2025, provided: "[This act] applies to conduct occurring on or after October 1, 2025."

33-2-2006. Onsite audits — preliminary and final reports — appeals. For audits conducted onsite, the following provisions apply:

(1) An entity that audits a pharmacy shall provide the pharmacy with a preliminary audit report, delivered to the pharmacy or its corporate office of record within 60 days after completion of the audit.

(2) A pharmacy has 30 days following receipt of the preliminary audit report to respond to questions, provide additional documentation, and comment on and clarify findings of the audit. The date of receipt of the report must be determined by the postmark date or the date of the electronic transmission if transferred electronically.

(3) If an audit results in the dispute or denial of a claim, the entity conducting the audit shall allow the pharmacy, for 30 days following receipt of the preliminary audit report, to produce additional claims documentation using any commercially reasonable method, including fax, mail, or e-mail.

(4) (a) Within 120 days after the completion of the appeals process under subsection (5), a final audit report must be delivered to the pharmacy or its corporate office of record.

(b) The final audit report must include a disclosure of any money recovered by the entity that conducted the audit.

(5) An entity that audits a pharmacy shall establish a written policy for a pharmacy to appeal a final audit report. If no remedies are specified by contract or in the pharmacy services manual, the pharmacy may seek to resolve the dispute through mediation.

History: En. Sec. 6, Ch. 114, L. 2013.

Part 21
Corporate Governance Annual Disclosure

33-2-2101. Short title. This part may be cited as the "Corporate Governance Annual Disclosure Act".

History: En. Sec. 1, Ch. 9, L. 2017.

33-2-2102. Purpose — scope. (1) The purpose of this part is to:

(a) provide to the insurance commissioner a summary of an insurer or insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework;

(b) outline the requirements for completing a corporate governance annual disclosure with the insurance commissioner; and

(c) provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information and that, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(2) (a) Nothing in this part may be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law.

(b) Notwithstanding subsection (2)(a), nothing in this part may be construed to limit the commissioner's authority or the rights or obligations of third parties under Title 33.

(3) The requirements of this part apply to all insurers domiciled in the state.

History: En. Sec. 2, Ch. 9, L. 2017.

33-2-2103. Definitions. As used in this part, the following definitions apply:

(1) "CGAD" means a corporate governance annual disclosure, a confidential report filed by the insurer or insurance group made in accordance with the requirements of this part.

(2) "Commissioner" means the insurance commissioner of the state of Montana.

(3) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in 33-2-1101.

(4) "Insurer" has the meaning provided in 33-1-201, except that it may not include agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(5) "NAIC" means the national association of insurance commissioners.

History: En. Sec. 3, Ch. 9, L. 2017.

33-2-2104. Disclosure requirement. (1) An insurer or the insurance group of which the insurer is a member shall, no later than June 1 of each calendar year, submit to the commissioner a CGAD that contains the information described in 33-2-2106. Notwithstanding any request from the commissioner made pursuant to subsection (3), if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the financial analysis handbook adopted by rule by the commissioner.

(2) The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee of the board of directors.

(3) An insurer not required to submit a CGAD under this section shall do so upon the commissioner's request.

(4) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending on how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(5) The review of the CGAD and any additional requests for information must be made through the lead state as determined by the procedures within the financial analysis handbook referenced in subsection (1).

(6) Insurers providing information substantially similar to the information required by this part in other documents provided to the commissioner, including a proxy statement filed in conjunction with form B requirements, or other state or federal filings provided to the commissioner may not be required to duplicate that information in the CGAD but may only be required to cross-reference the document in which the information is included.

History: En. Sec. 4, Ch. 9, L. 2017.

33-2-2105. Rulemaking authority. The commissioner may, upon notice and opportunity for all interested persons to be heard, issue rules and orders necessary to carry out the provisions of this part.

History: En. Sec. 5, Ch. 9, L. 2017.

33-2-2106. Contents of corporate governance annual disclosure. (1) The insurer or insurance group has discretion over the responses to the CGAD inquiries provided that the CGAD contains the material information necessary to permit the commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies, and practices. The commissioner may request additional information that the commissioner deems material and necessary to provide a clear understanding of the corporate governance policies, the reporting or information system, or controls implementing those policies.

(2) Notwithstanding subsection (1), the CGAD must be prepared consistent with any rules adopted by the commissioner. Documentation and supporting information must be maintained and made available upon examination or upon request of the commissioner.

History: **En. Sec. 6, Ch. 9, L. 2017.**

33-2-2107. Confidentiality. (1) Documents, materials, or other information, including the CGAD, in the possession or control of the department of insurance that are obtained by, created by, or disclosed to the commissioner or any other person under this part are recognized by the state as being proprietary and to contain trade secrets. These documents, materials, and other information are confidential by law and privileged, may not be subject to Title 2, chapter 6, part 10, may not be subject to subpoena, and may not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner may not otherwise make the documents, materials, or other information public without the prior written consent of the insurer. Nothing in this section may be construed to require written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other CGAD-related information pursuant to subsection (3) to assist in the performance of the commissioner's regular duties.

(2) Neither the commissioner nor any person who receives documents, materials, or other CGAD-related information, through examination or otherwise, while acting under the authority of the commissioner or with whom the documents, materials, or other information are shared pursuant to this part may be permitted or required to testify in any private civil action concerning any confidential documents, materials, or other information subject to subsection (1).

(3) In order to assist in the performance of the commissioner's regular duties, the commissioner may:

(a) upon request, share documents, materials, or other CGAD-related information, including the confidential and privileged documents, materials, or information subject to subsection (1), including proprietary and trade secret documents and materials with other state, federal, and international financial regulatory agencies, including members of any supervisory college as provided in Title 33, chapter 2, part 11, with the NAIC and with third-party consultants pursuant to 33-2-2108, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material, or other information and has verified in writing the legal authority to maintain confidentiality; and

(b) receive documents, materials, or other CGAD-related information, including otherwise confidential and privileged documents, materials, or information, including proprietary and trade secret information or documents, from regulatory officials of other state, federal, and international financial regulatory agencies, including members of any supervisory college as provided in Title 33, chapter 2, part 11, and from the NAIC, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(4) The sharing of information and documents by the commissioner pursuant to this part does not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of the provisions of this part.

(5) A waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade secret materials, or other CGAD-related information may not occur as a result of disclosure of such CGAD-related information or documents to the commissioner under this section or as a result of sharing as authorized in this part.

History: **En. Sec. 7, Ch. 9, L. 2017.**

33-2-2108. NAIC and third-party consultants. (1) The commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not otherwise a part of the commissioner's staff, as may be reasonably necessary to assist the commissioner in reviewing the CGAD and related information or the insurer's compliance with this part.

(2) Any persons retained under subsection (1) must be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(3) The NAIC and third-party consultants must be subject to the same confidentiality standards and requirements as the commissioner.

(4) As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with the conflict and to comply with the confidentiality standards and requirements of this part.

(5) A written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this part must contain the following provisions and expressly require the written consent of the insurer prior to making public any information provided under this part:

(a) specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this part;

(b) procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement must provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality.

(c) a provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the department of insurance and that the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner;

(d) a provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this part in a permanent database after the underlying analysis is completed;

(e) a provision requiring the NAIC or a third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(f) a requirement that the NAIC or a third-party consultant consent to intervention by an insurer in any judicial or administrative action in which the NAIC or the third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or the third-party consultant pursuant to this part.

History: En. Sec. 8, Ch. 9, L. 2017.

33-2-2109. Sanctions — penalties. Any insurer failing, without just cause, to timely file the CGAD as required in this part shall, after notice and hearing, pay a penalty of $100 for each day's delay to the commissioner. The penalty must be collected by the commissioner in the name of the state of Montana and deposited in the general fund. The maximum penalty under this section is $1 million. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

History: En. Sec. 9, Ch. 9, L. 2017.

Part 22
Private Air Ambulance Services

33-2-2201. Certificate of authority required. (1) A private air ambulance service subject to this part shall obtain a certificate of authority from the commissioner prior to selling, soliciting, or negotiating a membership agreement in Montana.

(2) A private air ambulance service applying for a certificate of authority shall submit an application on a form prescribed by the commissioner.

(3) The commissioner may issue a certificate of authority if the private air ambulance service has complied with the applicable provisions of Title 50 and this title unless the commissioner finds that issuance of the certificate of authority is contrary to the public interest.

(4) A private air ambulance service may renew its certificate of authority upon payment of the annual fee specified in 33-2-2202 on or before March 1 of each year and upon continued compliance with the applicable provisions of Title 50 and this title.

(5) The requirements of this section are in addition to any other licensing or registration requirements that apply to the private air ambulance service.

History: **En. Sec. 1, Ch. 210, L. 2017.**

33-2-2202. Fees. A private air ambulance service subject to this part shall pay the following fees to the commissioner for services rendered:

(1) issuance of a certificate of authority, $300;

(2) annual renewal fee, $300; and

(3) filing of a membership agreement or other forms, $50.

History: **En. Sec. 2, Ch. 210, L. 2017.**

33-2-2203. Suspension or revocation. (1) The commissioner may suspend or revoke a private air ambulance service certificate of authority if the private air ambulance service:

(a) no longer meets the requirements for the certificate of authority;

(b) materially fails to comply with a membership agreement issued to residents of Montana;

(c) is in unsound fiscal condition or is demonstrated to be using methods or practices in the conduct of its business that render its further transaction of insurance in this state injurious or hazardous to its members or to the public; or

(d) violates an applicable provision of law.

(2) Unless otherwise provided in the order of suspension or revocation, the private air ambulance service shall continue to honor membership agreements that are in force at the time of revocation or suspension.

History: **En. Sec. 4, Ch. 210, L. 2017.**

33-2-2204 and 33-2-2205 reserved.

33-2-2206. Membership agreement — contents. A membership agreement issued under this part must contain:

(1) the effective dates of the membership agreement;

(2) a grace period of 30 days for payment of a renewal membership fee;

(3) a description of what constitutes acceptable insurance coverage if eligibility for the membership agreement is conditioned on the member's current and continuing health insurance coverage;

(4) a statement that, except for decisions made as provided in 33-1-102(6), individuals enrolled in medicare, medicaid, or the healthy Montana kids plan under Title 53, chapter 4, part 11, are not subject to charges billed by a private air ambulance service in excess of applicable deductibles, coinsurance, and copayments;

(5) a statement that the membership agreement is an insurance contract;

(6) a description and graphic illustration of the base locations and effective coverage area of the private air ambulance service;

(7) a list of other private air ambulance services with which reciprocity exists under 50-6-320;

(8) a statement that:

(a) participation in a membership program does not guarantee that in the event of a transport, the private air ambulance service will provide the transport; and

(b) unless reciprocity exists under 50-6-320, if another private air ambulance service provides the transport, the individual will not receive the benefits provided under the membership agreement; and

(9) a definition of "medical necessity" if membership coverage of a transport is conditioned on a finding of medical necessity.

History: **En. Sec. 6, Ch. 210, L. 2017.**

33-2-2207. Filings. (1) Pursuant to Title 33, chapter 1, part 5, a private air ambulance service subject to this part shall file for approval any membership agreement, including any rider or endorsement.

(2) A filing under subsection (1) must include all fee schedules associated with the membership agreement.

History: En. Sec. 3, Ch. 210, L. 2017.

33-2-2208. Trade practices. (1) A private air ambulance service subject to this part may not use health status as a reason to:

(a) refuse to issue or renew a membership agreement;

(b) assess a differing rate or charge for the membership agreement; or

(c) exclude a specific individual for a membership agreement issued for a household or other group of individuals.

(2) A private air ambulance service subject to this part may not sell, solicit, negotiate, or advertise a membership program in a geographic area for which the private air ambulance does not routinely provide service.

(3) Except as provided in subsection (4)(b), if membership coverage of a transport is conditioned on a finding of medical necessity, a qualified medical professional shall render the determination.

(4) A membership agreement requirement of medical necessity is satisfied if:

(a) the treating physician requesting the transport certifies that the transport is medically necessary; or

(b) the member's insurer determines that the transport is medically necessary.

History: En. Sec. 5, Ch. 210, L. 2017.

33-2-2209 and 33-2-2210 reserved.

33-2-2211. Recordkeeping requirements. (1) A private air ambulance service subject to this part shall keep records of:

(a) all insurance transactions conducted in Montana; and

(b) all transports provided to individuals entering into membership agreements.

(2) A private air ambulance service subject to this section shall make the records under subsection (1) available to the commissioner on request.

History: En. Sec. 7, Ch. 210, L. 2017.

33-2-2212. Relationship to other laws. (1) Except as provided in subsection (2), the chapters and provisions of this title do not apply to a private air ambulance service.

(2) Title 33, chapter 1, parts 3, 4, 5, 12, and 13, chapter 18, parts 2 and 10, and chapter 19 as well as this part apply to a private air ambulance service that offers a membership program covering out-of-pocket expenses in excess of deductibles, copays, and coinsurance incurred for out-of-network services using the private air ambulance service or to private air ambulance services that are out-of-network and with which the membership program has reciprocity.

(3) A membership program of the type described in subsection (2) is insurance as defined in 33-1-201.

History: En. Sec. 8, Ch. 210, L. 2017.

33-2-2213. Rulemaking authority. The department shall adopt rules necessary to implement this part.

History: En. Sec. 9, Ch. 210, L. 2017.

Part 23
Air Ambulance Providers and Insurers

33-2-2301. Legislative findings and purpose. (1) The legislature finds that:

(a) air ambulance services provide a necessary, and sometimes lifesaving, means of transporting Montanans experiencing health emergencies;

(b) Montanans desire adequate access to air ambulance services;

(c) in many cases the high charges assessed by out-of-network air ambulance services and limited insurer and health plan reimbursements have resulted in Montanans incurring excessive out-of-pocket expenses; and

(d) the federal Airline Deregulation Act preempts states from enacting any law related to a price, route, or service of an air carrier, which is interpreted as applying to air ambulance services.

(2) The purpose of this part is to prevent Montanans from incurring excessive out-of-pocket expenses in out-of-network air ambulance situations in a manner that is not preempted by the Airline Deregulation Act.

History: En. Sec. 1, Ch. 231, L. 2017.

33-2-2302. Hold harmless. (1) If a covered person receives services from a non-Montana hospital-controlled out-of-network air ambulance service for an emergency medical condition, an insurer or health plan shall assume the covered person's responsibility, if any, for amounts charged in excess of allowed amounts for covered services and supplies, applicable copayments, coinsurance, and deductibles.

(2) An insurer or health plan that assumes a responsibility pursuant to subsection (1) shall notify the air ambulance service of that assumption no later than the date the insurer or health plan issues payment under subsection (4).

(3) If an air ambulance service receives notice pursuant to subsection (2), with the exception of amounts owed for applicable copayments, coinsurance, and deductibles, the air ambulance service may not:

(a) bill, collect, or attempt to collect from the covered person for the responsibility assumed under subsection (1);

(b) report to a consumer reporting agency that the covered person is delinquent on the responsibility assumed under subsection (1); or

(c) obtain a lien on the covered person's property in connection with the responsibility assumed under subsection (1).

(4) (a) An insurer or health plan is responsible for payment or denial of a claim within 30 days after receipt of a proof of loss, except as provided in 33-18-232(1). Within the timeframe provided in this subsection (4)(a), the insurer or health plan shall notify the covered person of the amount of deductible, coinsurance, or copayment that is the covered person's responsibility to pay.

(b) The insurer or health plan responsible under subsection (1) shall make payment based on:

(i) the billed charges of the air ambulance service;

(ii) another amount negotiated with the air ambulance service; or

(iii) the median amount the insurer or health plan would pay to an in-network air ambulance service for the services performed.

(5) If after payment is made under subsection (4) the insurer or health plan and air ambulance service dispute whether any further payment obligation exists, the insurer or health plan and air ambulance service shall enter into the dispute resolution process set forth in 33-2-2304 through 33-2-2306. After the independent dispute resolution process is exhausted, the aggrieved party may pursue any available remedies in a court of competent jurisdiction.

(6) For the purposes of this section:

(a) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a person who possesses knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(i) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part; and

(b) "insurer" means a health insurance issuer as defined in 33-22-140 and includes issuers of health insurance under Titles 2 and 20.

(7) This part does not apply if a covered person used an air ambulance membership subscription, as provided in 50-6-320, for the services provided by the air ambulance service.

History: En. Sec. 2, Ch. 231, L. 2017.

33-2-2303. Disclosures by air ambulance service. An out-of-network nonhospital-controlled air ambulance service must disclose by July 1 of each year any relationships or financial arrangements with health care providers, insurers, or health plans. This includes but is not limited to employment arrangements, ownership interests, first call agreements, and board memberships. This information must be filed with the department of public health and human services and also posted prominently on the commissioner of insurance's website. The air ambulance service must ensure the continued accuracy of this information throughout the year by submitting written updates within 5 days of any changes to the information.

History: En. Sec. 3, Ch. 231, L. 2017.

33-2-2304. Independent dispute resolution. (1) If an insurer or health plan and air ambulance service enter into dispute resolution, the procedure in 33-2-2305 is to be used to determine the fair market price of the services that are the subject of the claim.

(2) Payment of the fair market price calculated pursuant to 33-2-2305 constitutes payment in full of the claim.

(3) A determination under this section is not binding on the insurer or health plan and the air ambulance service.

(4) Unless otherwise agreed to by the parties, each party shall:

(a) bear its own attorney fees and costs incurred under the procedure provided in 33-2-2305; and

(b) equally bear all fees and costs of the independent reviewer.

(5) As used in this section, "fair market price" means the value of the services provided as determined by the independent reviewer based on the factors provided in 33-2-2305(6).

History: En. Sec. 4, Ch. 231, L. 2017.

33-2-2305. Independent dispute resolution procedure — exemptions. (1) To initiate a dispute resolution procedure under this part, the parties shall file a written notice of dispute with the insurance commissioner.

(2) Except as provided in subsection (3), within 30 days after the date of receipt of the notice of dispute, and if no independent reviewer is mutually agreed to by the insurer or health plan and air ambulance service under subsection (3), the insurance commissioner shall appoint an independent reviewer having the qualifications listed in 33-2-2306. The insurance commissioner shall select an independent reviewer randomly from a list established under 33-2-2306.

(3) The insurer or health plan and air ambulance provider may by mutual agreement select an independent reviewer. The parties shall notify the insurance commissioner of the mutually agreed independent reviewer prior to the appointment of an independent reviewer under subsection (2).

(4) An independent reviewer's sole substantive determination under this part is the fair market price of the services that are the subject of the claim.

(5) The independent reviewer may make procedural rulings necessary to regulate the proceedings.

(6) The factors to be used in the independent reviewer's determination are:

(a) the training, qualifications, and composition of the air ambulance service personnel;

(b) the fees for rotor wing or fixed wing services originating or provided entirely within the state of Montana that are:

(i) usually charged by the air ambulance service in Montana;

(ii) usually accepted as payment in full by the air ambulance service in Montana;

(iii) usually charged by other air ambulance services doing business in Montana;

(iv) usually accepted as payment in full by other air ambulance services doing business in Montana; and

(v) usually paid by the insurer or health plan for the service provided in Montana;

(c) whether the air ambulance service was provided in a rural or urban context;

(d) the applicable medicare rate of payment for the services that are the subject of the claim; and

(e) any other factors the independent reviewer determines to be relevant in determining fair market price in accordance with established precedent.

(7) Participation in a dispute resolution procedure under 33-2-2304 through 33-2-2306 exempts an insurer from 33-18-201(6) and (8) and 33-18-232(2).

History: En. Sec. 5, Ch. 231, L. 2017.

33-2-2306. Insurance commissioner duties — independent reviewer qualifications. (1) The insurance commissioner shall:

(a) approve any independent reviewer that is eligible to adjudicate disputes under this part;

(b) maintain a list of independent reviewers eligible to adjudicate disputes under this part;

(c) terminate approval of an independent reviewer and remove the independent reviewer from the list of approved independent reviewers upon determining that an independent reviewer no longer meets the requirements to adjudicate disputes; and

(d) adopt rules necessary to implement this part, including rules regarding discovery and other procedures regarding the dispute resolution process and eligibility of an independent reviewer.

(2) An individual is eligible to be an independent reviewer under this part if the individual is knowledgeable and experienced in applicable principles of contract and insurance law.

(3) In approving an individual as an independent reviewer, the insurance commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an independent dispute resolution procedure under 33-2-2304 and 33-2-2305. A conflict of interest includes but is not limited to an ownership or direct familial interest in an insurer, a health care provider, or an air ambulance service that may be involved in an independent dispute resolution procedure under 33-2-2304 and 33-2-2305.

(4) In approving an individual as an independent reviewer, the insurance commissioner may not approve an individual who is currently serving in any matter as a hearing officer for the commissioner.

History: En. Sec. 6, Ch. 231, L. 2017.

Part 24
Pharmacy Benefit Manager Oversight

33-2-2401. Short title — purpose. (1) This part may be cited as the "Montana Pharmacy Benefit Manager Oversight Act".

(2) This part establishes the standards and criteria for the licensure and regulation of pharmacy benefit managers that provide claims processing services or other prescription drug or device services for health benefit plans and workers' compensation insurance carriers.

(3) The purpose of this part is to:

(a) promote, preserve, and protect the public health, safety, and welfare through regulation and licensure of pharmacy benefit managers;

(b) provide for powers and duties of the commissioner in licensing and regulating pharmacy benefit managers; and

(c) provide penalties for violations of this part.

History: En. Sec. 1, Ch. 501, L. 2021.

33-2-2402. Definitions. As used in this part, the following definitions apply:

(1) "Claims processing services" means the administrative services performed in connection with the processing and adjudicating of claims relating to pharmacist services that include either or both of the following:

(a) receiving payments for pharmacist services; and

(b) making payments to pharmacists or pharmacies.

(2) "Enrollee" means a member, policyholder, subscriber, covered person, beneficiary, dependent, or other individual participating in a health benefit plan.

(3) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).

(4) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(5) (a) "Health carrier" means an entity that is subject to the insurance laws and regulations of this state or to the jurisdiction of the commissioner and that contracts or offers to contract or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(b) The term includes:

(i) self-funded multiple employer welfare arrangements as defined in 33-35-103; and

(ii) any other entity providing a plan of health insurance, health benefits, or health care services.

(6) "Manufacturer" has the meaning provided in 37-7-602.

(7) "Other prescription drug or device services" means services other than claims processing services that are provided directly or indirectly, whether in connection with or separate from claims processing services, including but not limited to:

(a) negotiating rebates, discounts, or other financial incentives and arrangements with manufacturers, wholesale distributors, or other third parties;

(b) disbursing or distributing rebates;

(c) managing or participating in incentive programs or arrangements for pharmacist services;

(d) negotiating or entering into contractual arrangements with pharmacists, pharmacies, or both;

(e) developing and maintaining formularies;

(f) designing prescription drug benefit programs;

(g) advertising or promoting services; or

(h) administering prior authorization, step therapy, case management, or other utilization review programs.

(8) "Pharmacist" has the meaning provided in 33-22-170.

(9) "Pharmacist services" means products, goods, and services or any combination of products, goods, and services provided as part of the practice of pharmacy.

(10) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7.

(11) (a) "Pharmacy benefit manager" means a person, including a wholly or partially owned or controlled subsidiary of a pharmacy benefit manager, that provides claims processing services or other prescription drug or device services, or both, to:

(i) enrollees who are residents of this state, for health benefit plans; or

(ii) injured workers of workers' compensation insurance carriers.

(b) The term does not include:

(i) a health care facility as defined in 50-5-101 that is licensed in this state;

(ii) a health care professional licensed under Title 37;

(iii) a consultant who provides advice only as to the selection or performance of a pharmacy benefit manager; or

(iv) a health carrier or workers' compensation insurance carrier to the extent that the carrier performs any claims processing and other prescription drug or device services exclusively for its enrollees or injured workers.

(12) "Pharmacy services administrative organization" means an entity that acts as a contracting agent or provides contracting and other administrative services to pharmacies to assist them in their interactions with third-party payers and pharmacy benefit managers.

(13) "Plan sponsor" has the meaning provided in 33-10-202.

(14) (a) "Rebates" means all price concessions, however characterized, paid by a manufacturer to a pharmacy benefit manager, including discounts and other remuneration or price concessions, that are based on the actual or estimated utilization of a prescription drug.

(b) The term includes price concessions based on the effectiveness of a prescription drug as in a value-based or performance-based contract.

(15) "Wholesale acquisition cost" has the meaning provided in 42 U.S.C. 1395w-3a.

(16) "Wholesale distributor" or "distributor" has the meaning provided in 37-7-602.

(17) "Workers' compensation insurance carrier" means:
(a) an insurance company transacting business under compensation plan No. 2; or
(b) the state fund compensation plan No. 3 under Title 39, chapter 71.

History: En. Sec. 2, Ch. 501, L. 2021; amd. Sec. 10, Ch. 157, L. 2023.

33-2-2403. Licensing required. (1) A person may not perform an act or do business in this state as a pharmacy benefit manager without a valid license issued under this part by the commissioner.

(2) A license issued under this part is nontransferable.

(3) A pharmacy benefit manager shall apply to the commissioner on a form prescribed by the commissioner. At a minimum, the application form must include the following information:

(a) the name, business address, and telephone number of the pharmacy benefit manager and the name, address, and contact information for the principal contact person of the pharmacy benefit manager for communications with the commissioner on licensure-related matters;

(b) the name and address of:

(i) all members of the pharmacy benefit manager's board of directors, board of trustees, executive committee, or other governing board of committee;

(ii) the principal officers in the case of a corporation; or

(iii) the partners or members in the case of a partnership or association;

(c) proof of registration with the Montana secretary of state;

(d) a copy of the most recent fiscal yearend audited financial statement of the pharmacy benefit manager;

(e) a list of all health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(f) a description of the projected number of enrollees and injured workers to be administered by the pharmacy benefit manager in this state on an annual basis for each health carrier client, plan sponsor client, and workers' compensation insurance carrier client;

(g) a copy of the policies and procedures that demonstrate the pharmacy benefit manager has established processes to comply with the requirements of 33-22-170 through 33-22-177 and 33-22-180 concerning maximum allowable costs lists, including the appeals process required under 33-22-173;

(h) a description of the pharmacy benefit manager's network service areas and pharmacy accessibility in this state;

(i) disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary in a pharmacy or mail-order pharmacy that is part of the pharmacy benefit manager's network; and

(j) disclosure of any ownership interest, either directly or indirectly or through an affiliate, holding company, or subsidiary by a health carrier or workers' compensation insurance carrier in the pharmacy benefit manager or by the pharmacy benefit manager in a health carrier or workers' compensation insurance carrier.

(4) Each application for licensure must be accompanied by a nonrefundable fee of $1,000.

(5) The commissioner may require additional information for submission from an applicant and may obtain any document or information reasonably necessary to verify the information contained in an application.

(6) The commissioner may refuse to issue or renew a license if the commissioner finds that the applicant:

(a) is not competent, trustworthy, or financially responsible;

(b) has violated the insurance laws of this state, including violation of 33-22-170 through 33-22-177 and 33-22-180, or any other state; or

(c) has had an insurance or other certificate of authority or license denied or revoked for cause by any jurisdiction.

(7) The commissioner shall grant or deny an initial application for a license within 60 days from the date that a completed application and license fee is received.

(8) (a) Unless surrendered, suspended, or revoked by the commissioner, a license issued under this section is valid as long as the pharmacy benefit manager:

(i) continues to do business in this state;

(ii) remains in compliance with the provisions of this part;

(iii) completes a renewal application on a form prescribed by the commissioner; and

(iv) pays an annual license renewal fee of $500.

(b) The renewal fee and application must be received by the commissioner at least 30 days before the anniversary of the effective date of the pharmacy benefit manager's initial or most recent license.

(9) Denial of an application for initial licensure or renewal of licensure is considered a contested case under the Montana Administrative Procedure Act.

(10) In lieu of denying an application for initial licensure or renewal of licensure, the commissioner may allow the pharmacy benefit manager to submit a corrective action plan to cure or correct the deficiencies identified in review of the application.

History: En. Sec. 3, Ch. 501, L. 2021.

33-2-2404. Pharmacy benefit manager prohibited practices. (1) In any participation contracts between a pharmacy benefit manager and pharmacies, pharmacists, or pharmacy services administrative organizations, a pharmacy or pharmacist may not be prohibited, restricted, or penalized in any way from disclosing to any enrollee or injured worker any information the pharmacy or pharmacist considers appropriate regarding:

(a) the decision of utilization reviewers or similar persons to authorize or deny drug coverage or benefits; and

(b) the process that is used to authorize or deny drug coverage or benefits.

(2) (a) A pharmacy benefit manager contract with a participating pharmacy, pharmacist, or a pharmacy services administrative organization in this state may not prohibit, restrict, or limit disclosure of information to the commissioner when the commissioner is investigating or examining a complaint or conducting a review of a pharmacy benefit manager's compliance with the requirements of this part.

(b) A pharmacy benefit manager may not terminate the contract of or penalize a pharmacy, pharmacist, or a pharmacy services administrative organization for sharing any portion of the pharmacy benefit manager contract with the commissioner for investigation of a complaint or a question regarding whether the contract complies with this part.

(c) Any examination or review under this section must follow the examination procedures and requirements applicable to insurers under Title 33, chapter 1, part 4, including but not limited to the confidentiality provisions of 33-1-409.

History: En. Sec. 4, Ch. 501, L. 2021; amd. Sec. 11, Ch. 157, L. 2023.

33-2-2405. Marketing and advertising. (1) A pharmacy benefit manager may not cause or knowingly permit the use of an advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

(2) The commissioner may not review or approve a pharmacy benefit manager's marketing or advertising documents prior to use by the pharmacy benefit manager.

(3) The commissioner shall review complaints related to pharmacy benefit manager marketing and advertising material to determine whether the materials violate the provisions of this section.

History: En. Sec. 5, Ch. 501, L. 2021.

33-2-2406. Pharmacy benefit manager transparency to carriers and plan sponsors. (1) Beginning in the second quarter after the effective date of a contract between a pharmacy benefit manager and a health carrier, plan sponsor, or workers' compensation insurance carrier, the pharmacy benefit manager shall disclose, within 45 days of a request of the health carrier, plan sponsor, or workers' compensation insurance carrier, the following information regarding prescription drug benefits specific to the health carrier, plan sponsor, or workers' compensation insurance carrier:

(a) the aggregate wholesale acquisition costs from a manufacturer or wholesale distributor for each therapeutic category of prescription drugs;

(b) the aggregate wholesale acquisition costs from a manufacturer or wholesale distributor for each therapeutic category of prescription drugs available to enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation insurance carrier;

(c) the aggregate amount of rebates received by the pharmacy benefit manager by therapeutic category of prescription drugs;

(d) any other fees received from a manufacturer or wholesale distributor and the reason for the fees;

(e) whether the pharmacy benefit manager has a contract, agreement, or other arrangement with a manufacturer to exclusively dispense or provide a drug to enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation carrier, and the application of all consideration or economic benefits collected or received pursuant to the arrangement;

(f) prescription drug utilization information for enrollees of the health carrier or plan sponsor or injured workers of the workers' compensation carrier, including but not limited to:

(i) the top 10 prescription drugs by average total spending for each enrollee or injured worker;

(ii) the top 10 prescription drugs by average out-of-pocket spending for each enrollee or injured worker;

(iii) the top 10 therapeutic classes of prescription drugs by total spending and volume;

(iv) the total number of pharmacy transactions; and

(v) the total number of rejected pharmacy transactions, including a breakdown of the number rejected for the following reasons:

(A) nonformulary status;

(B) prior authorization requirements; and

(C) step therapy requirements;

(g) de-identified claims-level information in electronic format that allows the health carrier, plan sponsor, or workers' compensation insurance carrier to sort and analyze the following information for each claim:

(i) whether the claim required prior authorization;

(ii) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy, including point-of-sale and retroactive charges;

(iii) any spread between the net amount paid to the pharmacy as described in subsection (1)(g)(ii) and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier;

(iv) whether the pharmacy is or is not:

(A) under common control or ownership with the pharmacy benefit manager;

(B) a preferred pharmacy for the health benefit plan or workers' compensation insurance carrier; or

(C) a mail-order pharmacy; and

(v) whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy;

(h) the aggregate amount of payments made by the pharmacy benefit manager on behalf of the health carrier, plan sponsor, or workers' compensation insurance carrier to:

(i) pharmacies owned or controlled by the pharmacy benefit manager; and

(ii) pharmacies not owned or controlled by the pharmacy benefit manager; and

(i) the aggregate amount of the fees imposed on or collected from network pharmacies or other assessments against network pharmacies, including point-of-sale fees and retroactive charges, and the amount of fees passed on to the health carrier, plan sponsor, or workers' compensation insurance carrier pursuant to the contract with the health carrier, plan sponsor, or workers' compensation insurance carrier.

(2) A health carrier, plan sponsor, or workers' compensation insurance carrier may request more detailed data from the pharmacy manager for any aggregate data provided under this section, including information to verify the pharmacy benefit manager's source of and reported amounts of rebates and fees.

(3) A pharmacy benefit manager may require a health carrier, plan sponsor, or workers' compensation insurance carrier to agree to a nondisclosure agreement that specifies that the information reported under this section is proprietary information. A pharmacy benefit manager requiring the use of a nondisclosure agreement is not required to disclose information under this section to the health carrier, plan sponsor, or workers' compensation insurance carrier until the health carrier, plan sponsor, or workers' compensation insurance carrier has executed the nondisclosure agreement.

History: En. Sec. 6, Ch. 501, L. 2021.

33-2-2407. Transparency report to the commissioner. (1) By July 1 each year for the immediately preceding calendar year, each pharmacy benefit manager doing business in this state shall report to the commissioner on a form prescribed by the commissioner the following information regarding prescription drug benefits provided to enrollees of each health carrier and plan sponsor and injured workers of workers' compensation insurance carriers in the state with which the pharmacy benefit manager has contracted during the previous calendar year:

(a) the aggregate prescription drug spending for all of the pharmacy benefit manager's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(b) the aggregate prescription drug spending as described in subsection (1)(a) net of all rebates and other fees and payments, direct or indirect, from all sources;

(c) the aggregate dollar amount of all rebates that the pharmacy benefit manager received from all manufacturers for all health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(d) the aggregate dollar amount of all fees from all sources, direct or indirect, that the pharmacy benefit manager received for all of the pharmacy benefit manager's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state and the reason for the fees;

(e) the aggregate dollar amount of all retained rebates and fees, as listed in subsection (1)(d), that the pharmacy benefit manager received from all sources, direct or indirect, that were not passed through to health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(f) the aggregate retained rebate and fees percentage;

(g) the highest, lowest, and mean aggregate retained rebate and fees percentage for all of the pharmacy benefit manager's health carrier, plan sponsor, and workers' compensation insurance carrier clients in this state;

(h) de-identified claims-level information in electronic format that allows the commissioner to sort and analyze the following information for each claim:

(i) the drug and quantity for each prescription;

(ii) whether the claim required prior authorization;

(iii) patient cost-sharing paid on each prescription;

(iv) the amount paid to the pharmacy for each prescription, net of the aggregate amount of fees or other assessments imposed on the pharmacy by the pharmacy benefit manager, including point-of-sale and retroactive charges;

(v) any spread between the net amount paid to the pharmacy as calculated in subsection (1)(h)(iv) and the amount charged to the health carrier, plan sponsor, or workers' compensation insurance carrier client;

(vi) the pharmacy used for each prescription;

(vii) whether the pharmacy is or is not:

(A) under common control or ownership with the pharmacy benefit manager;

(B) a preferred pharmacy under the health benefit plan; or

(C) a mail-order pharmacy; and

(viii) whether enrollees or injured workers are required by the health benefit plan or workers' compensation insurance carrier to use the pharmacy; and

(i) the aggregate amount of rebates passed on by the pharmacy benefit manager to the enrollees of each health carrier and plan sponsor client in this state at the point of sale that reduced the enrollee's applicable deductible, copayment, coinsurance, or other cost-sharing amount.

(2) For the purposes of this section, the aggregate retained rebate and fee percentage must be calculated for each health carrier, plan sponsor, and workers' compensation insurance carrier for rebates and fees received in the previous calendar year by dividing the sum total dollar amount of rebates and fees from all manufacturers for all utilization of enrollees of a health carrier or plan sponsor and injured workers of a workers' compensation insurance carrier that was not passed through to the health carrier, plan sponsor, or workers' compensation insurance carrier by the sum total dollar amount of all rebates and fees received from all sources, direct or indirect, for all enrollees of a health carrier or plan sponsor and injured workers of a workers' compensation insurance carrier.

(3) The commissioner may request more detailed information from a pharmacy benefit manager for any aggregate data reported under this section, including information to verify a pharmacy benefit manager's reported amounts of rebates and fees and their allocation to a health carrier, plan sponsor, or workers' compensation insurance carrier.

(4) On the request of a pharmacy benefit manager, the commissioner may exempt from disclosure any part of the pharmacy benefit manager's submission that the commissioner determines to contain trade secrets as defined in 30-14-402.

(5) (a) Information provided pursuant to subsections (1)(h)(iii) through (1)(h)(v) is considered a response to an examination under Title 33, chapter 1, part 4, and is subject to the confidentiality provisions of 33-1-409. Any data, documents, materials, or other information provided pursuant to those subsections is not subject to subpoena or discovery and is not admissible in evidence in any private civil action.

(b) The commissioner may use the data, documents, materials, or other information in the furtherance of a regulatory or legal action brought as part of the commissioner's official duties.

(6) (a) By December 31 of each year, the commissioner shall publish on the commissioner's website an aggregated rebate and fee transparency report based on the information submitted by each pharmacy benefit manager.

(b) The report may not contain information considered under this section to be confidential or a trade secret.

(c) The report must be published in a manner that does not disclose:

(i) the identity of a specific health carrier, plan sponsor, or workers' compensation insurance carrier;

(ii) the prices charged for a specific prescription drug or class of drugs; or

(iii) the amount of any rebates provided for a specific prescription drug or class of drugs.

(7) The commissioner may request the information required under this section at any time if the commissioner believes the information is reasonably necessary to ensure compliance with this part.

History: En. Sec. 7, Ch. 501, L. 2021.

33-2-2408. Pharmacy benefit manager appeals report. (1) Pharmacy benefit managers shall track, monitor, and report to the commissioner each quarter the following aggregated information related to appeals filed pursuant to 33-22-173:

(a) the number of appeals filed by pharmacies;

(b) whether the appeals were denied or upheld by the pharmacy benefit manager and, if denied, the reasons for the denials;

(c) for each denial, confirmation that the pharmacy benefit manager provided the pharmacy in writing the pricing and other information required under 33-22-173;

(d) the total amount of price adjustments made by the pharmacy benefit manager; and

(e) the average amount of days taken to make price adjustments.

(2) The report must be filed within 30 days of the close of each calendar quarter.

(3) The commissioner may request information required under this section at any time if the commissioner believes the information is reasonably necessary to ensure compliance with this part, 33-22-170 through 33-22-177, and 33-22-180.

History: En. Sec. 8, Ch. 501, L. 2021.

33-2-2409. Network adequacy. (1) A pharmacy benefit manager shall provide an adequate and accessible pharmacy network for the provision of prescription drugs to ensure reasonable proximity of pharmacies to the businesses or personal residences of enrollees and injured workers.

(2) In determining whether a pharmacy benefit manager has complied with the requirements of this section, consideration must be given to the relative availability of physical pharmacies in a geographic area.

(3) The commissioner shall adopt rules for network adequacy.

History: En. Sec. 9, Ch. 501, L. 2021.

33-2-2410. Federal 340B drug pricing program. A pharmacy benefit manager or health carrier may not:

(1) prohibit a federally certified health entity or a pharmacy under contract with an entity to provide pharmacy services from participating in the pharmacy benefit manager's or health carrier's provider network;

(2) reimburse a federally certified health entity or a pharmacy under contract with an entity differently than it reimburses other similarly situated pharmacies;

(3) require a claim for a drug to include a modifier to indicate that the drug is a 340B drug unless the claim is for payment, directly or indirectly, by the medicaid program provided for in Title 53, chapter 6, part 1; or

(4) create a restriction or an additional charge on a patient who chooses to receive drugs from a federally certified health entity or a pharmacy under contract with an entity, including but not limited to a patient's inability to fully pay a copayment. *(Subsection (3) terminates June 1, 2029—sec. 34, Ch. 8, L. 2025.)*

History: En. Sec. 10, Ch. 501, L. 2021.

Compiler's Comments

Extension of Termination Date: Section 34, Ch. 8, L. 2025, and sec. 36, Ch. 8, L. 2025, amended sec. 26, Ch. 501, L. 2021, and sec. 1, Ch. 259, L. 2023, by extending the termination dates imposed by those sections to June 1, 2029. Effective February 27, 2025.

33-2-2411. Enforcement — penalties. (1) The commissioner shall enforce the provisions of this part, 33-22-170 through 33-22-177, and 33-22-180 and may examine the affairs of a pharmacy benefit manager to determine compliance with the provisions.

(2) Any examination under this section must follow the examination procedures and requirements applicable to insurers under Title 33, chapter 1, part 4, including the confidentiality provisions of 33-1-409.

(3) A pharmacy benefit manager may not be regularly examined under the same time period as required of insurers under 33-1-401 but the commissioner may examine the pharmacy benefit manager at any time if the commissioner believes it is reasonably necessary to ensure compliance with this part.

(4) The commissioner may impose a fine in accordance with 33-1-317 and 33-1-318 for a violation of this part, 33-22-170 through 33-22-177, and 33-22-180.

History: En. Sec. 11, Ch. 501, L. 2021.

33-2-2412. Rulemaking. The commissioner may adopt rules as necessary to implement the provisions of this part.

History: En. Sec. 12, Ch. 501, L. 2021.

Part 25
Regulatory Waivers

33-2-2501. *(Temporary)* **Regulatory sandbox waiver — property or casualty insurers — application — considerations by the commissioner — limitations — rulemaking.** (1) The commissioner may grant a variance or waiver with respect to the requirements of an insurance law or rule if a property or casualty insurer, subject to that law or rule, demonstrates to the satisfaction of the commissioner that:

(a) the application of the law or rule would prohibit the introduction of an innovative or more efficient insurance product or service that the applicant intends to offer during the period the variance or waiver is granted;

(b) the public policy goals of the law or rule may be achieved by other means;

(c) the waiver may not substantially increase any risk to consumers;

(d) the waiver may not cause a material negative impact to the insurer in matters including but not limited to solvency; and

(e) the waiver is in the public interest.

(2) An application for a waiver must include the following information:

(a) the identity of the insurer applying for the waiver;

(b) the identity of the directors and executive officers of the insurer, any persons who are beneficial owners of 10% or more of the voting securities of the insurer, and any individuals with power to direct the management and policies of the insurer;

(c) a description of the product or service to be offered if the waiver is granted, including how the product or service functions and the manner and terms on which it must be offered;

(d) a description of the potential benefits to consumers of the product or service;

(e) a description of the potential risks, including but not limited to financial risks, to consumers posed by the product or service or approval of the proposed waiver and how the applicant proposes to mitigate the risks;

(f) a statement that the insurer has a physical presence in the state and has a certificate of authority issued by the commissioner to write insurance in the state;

(g) a filing fee of $1,000 unless the submission is complex and lengthy, in which case the commissioner may provide an estimate of the fee that is commensurate with regulatory costs for consideration of the submission. The insurer may withdraw the submission after receiving the estimate.

(h) if applicable, a request to segregate and protect from disclosure any confidential trade secrets in the application must be stated in the application with the confidential information specifically identified for the commissioner; and

(i) any additional information required by the commissioner.

(3) (a) If approved by the commissioner, an innovation waiver must be granted for an initial period of up to 3 years.

(b) Prior to the end of the waiver period, the commissioner may grant an extension for up to an additional 3 years. An extension request must be made to the commissioner at least 45 days prior to the end of the initial waiver period and must include the length of the extension period requested and specific reasons why the extension is necessary. The commissioner shall grant or deny an extension request before the end of the initial waiver period.

(4) A waiver must include any terms, conditions, or limitations considered appropriate by the commissioner, including limits on the amount of premium that may be written in relation to the underlying product or service and the number of consumers that may purchase or utilize the underlying product or service, provided that a product or service subject to an innovation waiver may not be purchased or utilized by more than 10,000 insureds. It is not an unlawful discriminatory practice by an insurer to refuse to provide a product or service subject to an innovation waiver when there is a legitimate basis to refuse to provide a product or service that is tied to the limitations or purpose supporting the waiver.

(5) A product or service offered pursuant to an innovation waiver must include the following written disclosures to consumers in clear and conspicuous form:

(a) the name and contact information for the representative of the insurer providing the product or service;

(b) that the product or service is authorized pursuant to an innovation waiver for a temporary period of time and may be discontinued at the end of the waiver period, the date of which must be specified;

(c) contact information for the commissioner, including how a consumer may file a complaint with the commissioner regarding the product or service; and

(d) any additional disclosures required by the commissioner.

(6) (a) The commissioner shall either grant or deny a waiver within 90 days of receipt of a completed request.

(b) The commissioner's decision to grant, deny, or revoke a waiver is not subject to the hearings and appeals provisions as provided in Title 33, chapter 1, part 7.

(7) The commissioner may not grant a waiver with respect to any of the following:

(a) any law, rule, or other provision that is not subject to the commissioner's jurisdiction;

(b) any law, rule, or other provision concerning the assets, deposits, investments, capital surplus, or other solvency requirements applicable to insurers;

(c) the required participation in any assigned risk plan, residual market, or guaranty fund;

(d) the provisions of Title 33 related to insurers other than property or casualty insurers;

(e) any law or rule required to maintain accreditation by the national association of insurance commissioners unless the law or rule permits variances or waivers and the effect of the waiver does not eliminate accreditation;

(f) the application of any taxes or fees; and

(g) any other law or rule considered ineligible by the commissioner.

(8) A person who receives a waiver under this section may be required to possess or obtain one or a combination of the following in an amount subject to the conditions and for the purposes as the commissioner determines necessary for the protection of consumers:

(a) a contractual liability insurance policy;

(b) a surety bond issued by an authorized surety;

(c) securities of the type eligible for deposit by authorized insurers in this state;

(d) evidence that the insurer has established an account payable to the commissioner in a federally insured financial institution in this state and has deposited money of the United States in an amount equal to the amount required by this subsection (8) that is not available for withdrawal except by direct order of the commissioner;

(e) a letter of credit issued by a qualified United States financial institution; or

(f) another form of security authorized by the commissioner.

(9) (a) If a waiver is granted pursuant to this section, the commissioner shall provide public notice of the existence of the waiver by providing the following information:

(i) the specific statute or rule to which the waiver applies;

(ii) the name of the insurer who applied for and received the waiver;

(iii) the duration and other terms, conditions, or limitations of the waiver; and

(iv) any additional information considered appropriate by the commissioner.

(b) The notice requirement of this subsection (9) may be satisfied by publication on the commissioner's website.

(10) (a) The commissioner may revoke a waiver if the insurer who obtains the waiver fails to comply with any terms, conditions, or limitations established by the commissioner or the requirements of this section or if the waiver is causing a consumer harm or causes material harm to the insurer's solvency.

(b) In addition to any other sanctions and penalties permitted by the law, the commissioner may impose a fine of not more than $1,000 on any insurer who obtains a waiver and fails to comply with the material terms, conditions, or limitations established by the commissioner or the requirements of this section.

(11) The commissioner, by rule, may adopt procedures for submissions and granting, denying, monitoring, and revoking petitions for a waiver pursuant to this section. The procedures must set forth requirements for the ongoing monitoring, examination, and supervision of and reporting by each insurer granted a waiver under this section and must permit the commissioner to attach reasonable conditions or limitations on the conduct permitted pursuant to a waiver. The procedures must provide for an expedited application process for a product or service that is substantially similar to one for which a waiver has previously been granted by the commissioner.

(12) On expiration of an innovation waiver, the insurer who obtained the waiver shall cease all activities that were permitted only as a result of the waiver and comply with all applicable laws and rules.

(13) The ability to grant a waiver under this section may not be interpreted to limit or otherwise affect the authority of the commissioner to exercise discretion to waive or enforce requirements as permitted under any other section of this title or any rules.

(14) A waiver may not be granted that extends beyond July 30, 2029. *(Terminates July 30, 2029—sec. 5, Ch. 546, L. 2023.)*

History: En. Sec. 1, Ch. 546, L. 2023.

CHAPTER 3
DOMESTIC STOCK AND MUTUAL INSURERS

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Part 1
General Provisions

33-3-101. Scope of chapter. This chapter shall apply only to domestic stock insurers and domestic mutual insurers transacting or proposing to transact insurance on the cash premium or legal reserve plan, except that 33-3-414(2) and 33-3-503 shall also apply to foreign and alien insurers.

History: En. Sec. 418, Ch. 286, L. 1959; R.C.M. 1947, 40-4701.

33-3-102. Definitions. (1) A "domestic mutual insurer" is an incorporated insurer without capital stock, and the governing body of which is elected by the policyholders.

(2) A "domestic stock insurer" is an incorporated insurer with capital divided into shares and owned by its stockholders.

History: En. Secs. 419, 420, Ch. 286, L. 1959; R.C.M. 1947, 40-4702, 40-4703.

33-3-103. Applicability of general corporation statutes. (1) The applicable laws of this state as to domestic corporations formed for profit shall apply as to domestic stock insurers and domestic mutual insurers except where in conflict with the express provisions of this code and the reasonable implications of such provisions.

(2) Except as provided in part 6 of this chapter, 35-14-1401 through 35-14-1405 apply to the voluntary dissolution of a domestic insurer.

History: En. Sec. 421, Ch. 286, L. 1959; R.C.M. 1947, 40-4704; amd. Sec. 1, Ch. 389, L. 1987; amd. Sec. 188, Ch. 368, L. 1991; amd. Sec. 231, Ch. 271, L. 2019.

Cross-References

Business corporations, Title 35, ch. 14.

33-3-104. Extinguishment of unused corporate charters. (1) The corporate charter of any corporation formed under the laws of this state for the purpose of becoming an insurer, and which corporation during any period of 36 consecutive months after January 1, 1961, is not actively engaged in business as a domestic insurer under a certificate of authority issued to it by the commissioner under law currently in force, is automatically hereby extinguished and nullified at the expiration of such 36-month period.

(2) The period during which any such corporation referred to in subsection (1) above is the subject of delinquency proceedings under part 13, chapter 2, of this title shall not be counted as part of any such 36-month period.

History: En. Sec. 467, Ch. 286, L. 1959; R.C.M. 1947, 40-4750(2), (3); amd. Sec. 141, Ch. 575, L. 1981.

Cross-References

Certificate of authority, 33-2-101.

33-3-105. Commissioner's request of biographical information. (1) The commissioner may request from domestic insurers biographical information from officers, directors, and persons in a position to control the activity of the following entities:

(a) insurers provided for in Title 33, chapter 3;

(b) farm mutual insurers provided for in Title 33, chapter 4;

(c) reciprocal insurers provided for in Title 33, chapter 5;

(d) health service corporations provided for in Title 33, chapter 30;

(e) health maintenance organizations provided for in Title 33, chapter 31; and

(f) the state fund provided for in Title 39, chapter 71, part 23.

(2) Officers, directors, or other persons in a position to control the activity of the entities listed in subsection (1) shall submit biographical information on a form prescribed by the commissioner.

History: En. Sec. 2, Ch. 227, L. 2001; amd. Sec. 7, Ch. 62, L. 2019.

Part 2
Formation

33-3-201. Incorporation. (1) This section applies to stock and mutual insurers incorporated in this state.

(2) Five or more individuals, none of whom are less than 18 years of age, may incorporate a stock insurer. Ten or more individuals, none of whom are less than 18 years of age, may incorporate a mutual insurer. At least a majority of the incorporators must be citizens of the United States. At least a majority of the incorporators must be residents of this state.

(3) The incorporators shall execute articles of incorporation. The articles of incorporation must state the purpose for which the corporation is formed and must show:

(a) the name of the corporation. If a mutual corporation, the word "mutual" must be a part of the name. An alternative name or names may be specified for use in jurisdictions where a conflict of name with that of another insurer or organization might otherwise prevent the corporation from being authorized to transact insurance in that jurisdiction.

(b) the duration of its existence, which may be perpetual;

(c) the kinds of insurance, as defined in this code, which the corporation is formed to transact;

(d) if a stock corporation, its authorized capital stock, the number of shares of common stock, and the par value of each share. The par value must be at least $1. Shares without par value or other than one class of voting common stock are not authorized. The articles of incorporation may limit or deny present or future stockholders preemptive or preferential rights to acquire additional issues of the stock, bonds, debentures, or other obligations convertible into stock, of the corporation, subject to the laws of Montana fixing the required representation and proportion of outstanding capital stock required to be represented and voted, for specified action, at any and all corporate meetings, elections, votes, or consent proceedings.

(e) if a stock corporation, the extent, if any, to which shares of its stock are subject to assessment;

(f) if a stock corporation, the number of shares subscribed, if any, by each incorporator;

(g) if a mutual corporation, the maximum contingent liability of its members, other than as to nonassessable policies, for payment of losses and expenses incurred. Any liability must be stated in the articles of incorporation but may not be less than one or more than six times the premium for the member's policy at the annual premium rate for a term of 1 year.

(h) the minimum, not less than 5, and the maximum, not more than 21, number of directors who constitute the board of directors and conduct the affairs of the corporation, and the names, addresses, and terms of the members of the initial board of directors. The term of office of initial directors may not be for more than 1 year after the date of incorporation.

(i) the name of the county, and the city, town, or place within the county, in which its principal office or principal place of business is to be located in this state;

(j) any other provisions, not inconsistent with law, considered appropriate by the incorporators;

(k) the name and residence address of each incorporator and the citizenship of each incorporator who is not a citizen of the United States.

History: En. Sec. 422, Ch. 286, L. 1959; amd. Sec. 7, Ch. 423, L. 1971; amd. Sec. 18, Ch. 100, L. 1973; R.C.M. 1947, 40-4705; amd. Sec. 13, Ch. 380, L. 2003; amd. Sec. 3, Ch. 117, L. 2019; amd. Sec. 12, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 12, Ch. 8, L. 2025. Amendment effective October 1, 2025.

Cross-References

Types of insurance — definitions, 33-1-205 through 33-1-212.

33-3-202. Articles of incorporation — approval. (1) The incorporators of a proposed domestic insurer shall deliver an electronic copy of the proposed articles of incorporation to the commissioner. The commissioner shall examine the proposed articles of incorporation. If the commissioner finds that the articles comply with this chapter and are not in conflict with the constitution and laws of the United States or of this state, the commissioner shall approve the articles. However, if the commissioner finds that the proposed insurer would not be eligible for a certificate of authority under 33-2-112, the commissioner shall refuse to approve the articles of incorporation and shall provide in writing the reasons for the refusal. The commissioner shall forward the approved articles and the applicable fees to the secretary of state.

(2) If the commissioner finds that the proposed articles of incorporation do not comply with law, the commissioner shall refuse to approve the proposed articles of incorporation and shall provide a written statement of the reasons for the refusal.

(3) The corporation has legal existence as a corporation upon the issuance of the certificate of incorporation by the secretary of state, but the corporation may not transact business as an insurer until it has qualified for and received from the commissioner a certificate of authority as provided in this title.

(4) A copy of the certificate of incorporation, certified by the secretary of state, is admissible in all the courts of this state as prima facie evidence of proper incorporation.

History: **En. Sec. 423, Ch. 286, L. 1959; R.C.M. 1947, 40-4706; amd. Sec. 1, Ch. 373, L. 1983; amd. Sec. 5, Ch. 316, L. 1999; amd. Sec. 17, Ch. 472, L. 1999; amd. Sec. 8, Ch. 62, L. 2019; amd. Sec. 4, Ch. 117, L. 2019.**

Cross-References

Custody of records with Secretary of State, 2-15-406.

Administrative hearing before Commissioner, 33-1-701.

33-3-203. Amendment of articles of incorporation — grounds for disapproval. (1) A domestic stock insurer may amend its articles of incorporation for any lawful purpose by written authorization of the holders of a majority of the voting power of its outstanding capital stock or by affirmative vote of a majority voting at a lawful meeting of stockholders of which the notice given to stockholders included notice of the proposal to amend.

(2) A domestic mutual insurer may amend its articles of incorporation for any lawful purpose by affirmative vote of a majority of those of its members present or represented by proxy at a lawful meeting of its members of which the notice given members included notice of the proposal to amend.

(3) Upon adoption of an amendment, the insurer shall set forth the amendment and the date and manner of the amendment's adoption in articles of amendment. The articles of amendment must be executed by the insurer's president or vice president and secretary or assistant secretary and acknowledged by them before an officer authorized by law to take acknowledgments of deeds. The insurer shall deliver to the commissioner the articles of amendment. If the commissioner finds that the articles of amendment and the amendment comply with law, the amendment must be approved. The amendment is effective when it has been filed with the secretary of state.

(4) If the commissioner finds that the proposed amendment or the articles of amendment do not comply with the law, the commissioner may not approve the amendment or the articles of amendment and shall provide a written statement of reasons for nonapproval. The filing fee is not returnable.

(5) If an amendment of articles of incorporation would reduce the authorized capital stock of a stock insurer below the amount then outstanding, the commissioner may not approve the amendment if the commissioner has reason to believe that the interests of policyholders or creditors of the insurer would be materially prejudiced by the reduction. If a reduction of capital stock is realized, the insurer may require the return of the original certificates of stock held by each stockholder for exchange for new certificates for the number of shares as the stockholder is then entitled in the proportion that the reduced capital bears to the amount of capital stock outstanding as of immediately prior to the effective date of the reduction.

History: **En. Sec. 424, Ch. 286, L. 1959; R.C.M. 1947, 40-4707; amd. Sec. 6, Ch. 316, L. 1999; amd. Sec. 29, Ch. 227, L. 2001; amd. Sec. 5, Ch. 117, L. 2019.**

Cross-References

Hearings by Commissioner, 33-1-701.

33-3-204. Initial qualifications — domestic mutuals. (1) When newly organized, a domestic mutual insurer may be authorized to transact any of the kinds of insurance as are permitted under 33-2-108.

(2) When applying for an original certificate of authority, the insurer must be otherwise qualified therefor under this code and must have unimpaired surplus funds in an amount not less than the amount of paid-in capital stock required of a domestic stock insurer transacting like kinds of insurance as in 33-2-109, subject further to the additional special surplus requirements

of 33-2-110 applicable to such stock insurer. The minimum amount of surplus must thereafter be maintained unimpaired and placed on deposit with the commissioner. The deposit is subject to the provisions of chapter 2, part 6, of this title and 33-2-111.

History: **En. Sec. 425, Ch. 286, L. 1959; R.C.M. 1947, 40-4708; amd. Sec. 10, Ch. 303, L. 1981.**

Cross-References

Application for original certificate of authority, 33-2-115.

Curing impairment of capital deficiency — any lawful means authorized, 33-3-433.

33-3-205. Formation of mutual insurer — bond. (1) Before soliciting applications for insurance to raise surplus funds to qualify for the original certificate of authority, the incorporators of the proposed insurer shall file with the commissioner a corporate surety bond in the penalty of $50,000, in favor of the state and for the use and benefit of the state and of applicant members and creditors of the corporation. The bond shall be conditioned as follows:

(a) for the prompt return to applicant members of all premiums collected in advance;

(b) for payment of all indebtedness of the corporation; and

(c) for payment of costs incurred by the state in event of any legal proceedings for liquidation or dissolution of the corporation, all in the event the corporation fails to complete its organization and secure a certificate of authority within 1 year after the date of its certificate of incorporation.

(2) In lieu of such bond, the incorporators may deposit with the commissioner $50,000 in cash or United States government bonds, negotiable and payable to the bearer, with a market value at all times of not less than $50,000, to be held in trust upon the same conditions as required for the bond.

(3) Any such bond filed or deposit or remaining portion thereof held under this section shall be released and discharged upon settlement and termination of all liabilities against it.

History: **En. Sec. 426, Ch. 286, L. 1959; R.C.M. 1947, 40-4709; amd. Sec. 11, Ch. 303, L. 1981.**

Cross-References

Suretyship, Title 28, ch. 11, part 4.

33-3-206. Applications for insurance in formation of mutual insurer. (1) Upon receipt of the commissioner's approval of the bond or deposit as provided in 33-3-205, the directors and officers of the proposed domestic mutual insurer may commence solicitation of such requisite applications for insurance policies as they may accept and may receive deposits of premiums thereon.

(2) All such applications shall be in writing signed by the applicant, covering subjects of insurance resident, located, or to be performed in this state.

(3) All such applications shall provide that:

(a) issuance of the policy is contingent upon the insurer qualifying for and receiving a certificate of authority;

(b) no insurance is in effect unless and until the certificate of authority has been issued; and

(c) the prepaid premium or deposit and membership or policy fee, if any, shall be refunded in full to the applicant if organization is not completed and the certificate of authority is not issued and received by the insurer before a specified reasonable date, which date shall be not later than 1 year after the date of the certificate of incorporation.

(4) All qualifying premiums collected shall be in cash.

(5) Solicitation for such qualifying applicants for insurance shall be by licensed insurance producers of the corporation, and the commissioner shall, upon the corporation's application therefor, issue temporary insurance producer's licenses expiring on the date specified pursuant to subsection(3)(c) above to individuals qualified as for a resident insurance producer's license except as to the taking or passing of an examination. The commissioner may suspend or revoke any such license for any of the causes and pursuant to the same procedures as are applicable to suspension or revocation of licenses of insurance producers in general under chapter 17.

History: **En. Sec. 427, Ch. 286, L. 1959; R.C.M. 1947, 40-4710; amd. Sec. 1, Ch. 713, L. 1989.**

33-3-207. Formation of mutuals — trust deposit of premiums — issuance of policies. (1) All sums collected by a domestic mutual corporation as premiums or fees on qualifying applications for insurance therein shall be deposited in trust in a bank or trust company in this state under a written trust agreement consistent with this section and with 33-3-206(3)(c). The corporation shall file an executed copy of such trust agreement with the commissioner.

(2) Upon issuance to the corporation of a certificate of authority as an insurer for the kind of insurance for which such applications were solicited, all funds so held in trust shall become the funds of the insurer, and the insurer shall thereafter in due course issue and deliver its policies for which premiums had been paid and accepted. The insurance provided by such policies shall be effective as of the date of the certificate of authority or thereafter as provided by the respective policies.

History: En. Sec. 428, Ch. 286, L. 1959; R.C.M. 1947, 40-4711.

Cross-References

Banks and trust companies, Title 32, ch. 1.

33-3-208. Formation of mutuals — failure to qualify. If the proposed domestic insurer fails to complete its organization and to secure its original certificate of authority within 1 year after the date of its certificate of incorporation, its corporate powers shall cease and the commissioner shall return or cause to be returned to the persons entitled thereto all advance deposits or payments of premiums held in trust under 33-3-207.

History: En. Sec. 429, Ch. 286, L. 1959; R.C.M. 1947, 40-4712.

33-3-209 through 33-3-214 reserved.

33-3-215. Mutualization of stock insurer. (1) A stock insurer other than a title insurer may become a mutual insurer under a plan and procedure approved by the commissioner after a hearing thereon.

(2) The commissioner shall not approve any plan, procedure, or mutualization unless:

(a) it is equitable to stockholders and policyholders;

(b) it is subject to approval by the holders of not less than three-fourths of the insurer's outstanding capital stock having voting rights and by not less than two-thirds of the insurer's policyholders who vote on such plan in person, by proxy, or by mail pursuant to such notice and procedure as may be approved by the commissioner;

(c) if a life insurer, the right to vote thereon is limited to holders of policies other than term or group policies and whose policies have been in force for more than 1 year;

(d) mutualization will result in retirement of shares of the insurer's capital stock at a price not in excess of the fair market value thereof as determined by competent disinterested appraisers;

(e) the plan provides for the purchase of the shares of any nonconsenting stockholder in the same manner and subject to the same applicable conditions as provided by Title 35, chapter 14, part 13, as to rights of nonconsenting stockholders, with respect to consolidation or merger of private corporations;

(f) the plan provides for definite conditions to be fulfilled by a designated early date upon which such mutualization will be deemed effective; and

(g) the mutualization leaves the insurer with surplus funds reasonably adequate for the security of its policyholders and to enable it to continue successfully in business in the states in which it is then authorized to transact insurance and for the kinds of insurance included in its certificates of authority in such states.

(3) This section shall not apply to mutualization under order of court pursuant to rehabilitation or reorganization of an insurer under chapter 2, part 13.

History: En. Sec. 460, Ch. 286, L. 1959; R.C.M. 1947, 40-4743; amd. Sec. 13, Ch. 198, L. 1979; amd. Sec. 141, Ch. 575, L. 1981; amd. Sec. 232, Ch. 271, L. 2019.

Cross-References

Hearings by Commissioner, 33-1-701.

33-3-216. Converting mutual insurer to stock insurer. (1) A mutual insurer may become a stock insurer under a plan and procedure as may be approved by the commissioner after a hearing.

(2) The commissioner may not approve any plan or procedure unless:

(a) it is equitable to the insurer's members;

(b) it is subject to approval by vote of not less than three-fourths of the insurer's current members voting on the plan or procedure in person, by proxy, or by mail at a meeting of members called for the purpose pursuant to reasonable notice and procedure that may be approved by the commissioner. If the insurer is a life insurer, the right to vote may be limited to members who hold policies other than term or group policies and whose policies have been in force for not less than 1 year.

(c) the equity of each policyholder in the insurer is determinable under a fair formula approved by the commissioner, which equity must be based upon not less than the insurer's entire surplus, after deducting contributed or borrowed surplus funds, plus a reasonable present equity in its reserves and in all nonadmitted assets;

(d) the policyholders entitled to participate in the purchase of stock or distribution of assets must include all current policyholders and all existing persons who had been policyholders of the insurer within 3 years prior to the date the plan was submitted to the commissioner;

(e) the plan gives to each policyholder of the insurer, as specified in subsection (2)(d), a preemptive right to acquire the policyholder's proportionate part of all of the proposed capital stock of the insurer, within a designated reasonable period, and to apply upon the purchase of the stock the amount of the policyholder's equity in the insurer as determined under subsection (2)(c);

(f) shares are offered to policyholders at a price not greater than the price to be offered to others but at not more than double the par value of the shares;

(g) the plan provides for payment to each policyholder not electing to apply the policyholder's equity in the insurer for or upon the purchase price of stock to which preemptively entitled of cash in the amount of not less than 50% of the amount of the equity not used for the purchase of stock, and which cash payment together with stock purchased, if any, constitutes full payment and discharge of the policyholder's equity as an owner of the mutual insurer; and

(h) the plan, when completed, would provide for the converted insurer paid-in capital stock in an amount not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance, together with surplus funds in amount not less than one-half of the required capital.

History: **En. Sec. 461, Ch. 286, L. 1959; R.C.M. 1947, 40-4744; amd. Sec. 1132, Ch. 56, L. 2009.**

Cross-References

Hearings by Commissioner, 33-1-701.

33-3-217. Mergers and consolidations of stock insurers. (1) A domestic stock insurer may merge or consolidate with one or more domestic or foreign stock corporations authorized to transact business in this state by complying with the applicable provisions of the statutes of this state governing the merger or consolidation of stock corporations formed for profit but subject to subsections (2) and (3).

(2) A merger or consolidation may not be effectuated unless in advance of the merger or consolidation the plan and agreement for the merger or consolidation have been filed with the commissioner and approved in writing by the commissioner after a hearing. The commissioner shall give approval within a reasonable time after the filing unless the commissioner finds that the plan or agreement:

(a) is contrary to law;

(b) is inequitable to the stockholders of any domestic insurer involved; or

(c) would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state or elsewhere.

(3) A director, officer, insurance producer, or employee of any insurer that is party to the merger or consolidation may not receive any fee, commission, compensation, or other valuable consideration for in any manner aiding, promoting, or assisting in the merger or consolidation except as set forth in the plan or agreement.

(4) If the commissioner does not approve any plan or agreement, the commissioner shall notify the insurer in writing specifying the reasons for disapproval.

(5) If any domestic insurer involved in the proposed merger or consolidation is authorized to transact insurance in other states, the commissioner may request the insurance commissioner, director of insurance, superintendent of insurance, or other similar public insurance supervisory official of the two other states in which the insurer has in force the larger amounts of insurance

to participate in the hearing provided for under subsection (2), with full right to examine all witnesses and evidence and to offer to the commissioner pertinent information and suggestions that they may consider proper.

(6) Any plan or proposal through which a stock insurer proposes to acquire a controlling stock interest in another stock insurer through an exchange of stock of the first insurer, issued by the insurer for the purpose, for the controlling stock of the second insurer is considered to be a plan or proposal of merger of the second insurer into the first insurer for the purposes of this section and is subject to the applicable provisions of this section.

(7) Upon merger or consolidation of a domestic insurer with another insurer under this chapter, the corporate charter of the merged or consolidated domestic insurer must automatically be extinguished and nullified.

History: (1) thru (6)En. Sec. 462, Ch. 286, L. 1959; amd. Sec. 1, Ch. 151, L. 1971; Sec. 40-4745, R.C.M. 1947; (7)En. Sec. 467, Ch. 286, L. 1959; Sec. 40-4750, R.C.M. 1947; R.C.M. 1947, 40-4745, 40-4750(4); amd. Sec. 14, Ch. 198, L. 1979; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1133, Ch. 56, L. 2009.

Cross-References

Hearings by Commissioner, 33-1-701.

33-3-218. Mergers and consolidations of mutual insurers. (1) A domestic mutual insurer may not merge or consolidate with a stock insurer.

(2) A domestic mutual insurer may merge or consolidate with another mutual insurer under the applicable procedures prescribed by the statutes of this state applying to corporations formed for profit, except as provided in this section.

(3) The plan and agreement for merger or consolidation must be submitted to and approved by at least two-thirds of the members of each mutual insurer involved by voting on the issue at meetings called for the purpose pursuant to reasonable notice and procedure that has been approved by the commissioner. If the insurer is a life insurer, the right to vote may be limited to members whose policies are other than term and group policies and have been in effect for more than 1 year.

(4) A merger or consolidation may not be effectuated unless in advance of the merger or consolidation the plan and agreement for the merger or consolidation have been filed with the commissioner and approved by the commissioner after a hearing. The commissioner shall give approval within a reasonable time after the filing unless the commissioner finds that the plan or agreement:

(a) is inequitable to the policyholders of any domestic insurer involved; or

(b) would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state and elsewhere.

(5) If the commissioner does not approve the plan or agreement, the commissioner shall notify the insurers in writing specifying the reasons for disapproval.

(6) Section 33-3-217(5) also applies to mergers and consolidations of mutual insurers.

(7) Upon merger or consolidation of a domestic insurer with another insurer under this chapter, the corporate charter of the merged or consolidated domestic insurer must automatically be extinguished and nullified.

History: En. Secs. 463, 467, Ch. 286, L. 1959; R.C.M. 1947, 40-4746, 40-4750(4); amd. Sec. 1134, Ch. 56, L. 2009.

Cross-References

Hearings by Commissioner, 33-1-701.

Part 3
Management

33-3-301. Bylaws of mutual. (1) A domestic mutual insurer must have bylaws for the governing of its affairs. The initial board of directors of the insurer shall adopt original bylaws, subject to the approval of the insurer's members at the next meeting. The members have the power to make, modify, and revoke bylaws.

(2) The bylaws must provide:

(a) that each member is entitled to one vote upon each matter coming to a vote at meetings of members or to more votes in accordance with a reasonable classification of members as set forth in the bylaws and based upon the amount of insurance in force, upon the number of policies held or the amount of the premiums paid by the member, or upon other reasonable factors. A member has the right to vote in person or by written proxy. A proxy may not be irrevocable or for longer than a reasonable period of time.

(b) for election of directors by the members and the number, qualifications, terms of office, and powers of directors;

(c) the time, notice, quorum, and conduct of annual and special meetings of members and voting at the meetings. The bylaws may provide that the annual meeting must be held at a place, date, and time to be set forth in the policy and without giving other notice of the meeting.

(d) the number, designation, election, terms, and powers and duties of the respective corporate officers;

(e) for deposit, custody, disbursement, and accounting as to corporate funds;

(f) for any other reasonable provisions customary, necessary, or convenient for the management or regulation of its corporate affairs.

(3) A provision in the bylaws for determining a quorum of members at any meeting of less than a majority of all the insurer's members is not effective unless approved by the commissioner. This subsection may not affect any other provision of law requiring the vote of a larger percentage of members for a specified purpose.

(4) The insurer shall promptly file with the commissioner a copy, certified by the insurer's secretary, of its bylaws and of every modification of or addition to the bylaws. The commissioner shall disapprove any bylaw provision that the commissioner considers unlawful, unreasonable, inadequate, unfair, or detrimental to the proper interests or protection of the insurer's members or any class of members. The insurer may not, after receiving written notice of the disapproval and during the existence of the disapproval, effectuate any bylaw provision disapproved.

History: En. Sec. 432, Ch. 286, L. 1959; R.C.M. 1947, 40-4715; amd. Sec. 1135, Ch. 56, L. 2009.

33-3-302. Bylaws of stock insurer — modification. (1) A bylaw adopted at any meeting of stockholders of a domestic insurer may not be modified or revoked except by the stockholders at a subsequent meeting unless the bylaws as adopted or amended by the stockholders grant authority to the board of directors to revoke or modify bylaw provisions. The board of directors may not revoke or modify any bylaw relating to the qualifications, election, terms, or compensation of directors or to the calling or notice of meetings of stockholders. A revocation or modification of bylaws made by the directors under this provision must be presented at the next following meeting of stockholders for the information of the stockholders.

(2) The insurer shall promptly file with the commissioner a copy, certified by the insurer's secretary, of its bylaws and amended bylaws. The commissioner may disapprove any bylaw provision considered by the commissioner to be unlawful. The insurer may not, after receiving written notice of the commissioner's disapproval, enact any disapproved bylaw provision.

History: En. Sec. 433, Ch. 286, L. 1959; R.C.M. 1947, 40-4716; amd. Sec. 30, Ch. 227, L. 2001.

33-3-303. Meetings of stockholders or members. (1) Except with the commissioner's consent, meetings of stockholders or members of a domestic insurer must be held in the city or town of its principal office or place of business in this state.

(2) A meeting of stockholders or members may not amend the insurer's articles of incorporation unless the proposal to amend was included in the notice of the meeting.

(3) Except with the commissioner's consent, each insurer shall, during the first 6 months of each calendar year, hold the annual meeting of its stockholders or members to fill vacancies existing or occurring in the board of directors, must receive and shall consider reports of the insurer's officers as to its affairs, and shall transact other business properly brought before it. Not less than 20 days' notice must be given of the meeting in the manner provided in the bylaws, except when notice of the annual meeting of a mutual insurer is contained in its policies.

(4) Special meetings of the stockholders or members may be called at any time for any purpose by the board of directors upon not less than 10 days' notice, with notice given as provided in the bylaws. The notice must state the purpose of the meeting, and business for which notice was not given may not be transacted at the meeting.

(5) If more than 15 months elapse without an annual stockholders' or members' meeting being held, any stockholder or member may call for an annual meeting to be held. At any time, upon written request of any director or of any stockholders or members holding in the aggregate

one-fifth of the voting power of all stockholders or members, it is the duty of the secretary to call a special meeting of stockholders or members to be held at the time that the secretary may fix, not less than 10 or more than 30 days after the receipt of the request. If the secretary fails to issue a call, the director, stockholders, or members making the request may do so.

(6) A stockholders' or members' meeting duly held may be organized for the transaction of business whenever a quorum is present. Except as otherwise provided by law or the articles of incorporation:

(a) the presence, in person or by proxy, of the holders of a majority of the voting power of all stockholders or of all members constitutes a quorum;

(b) the stockholders or members present at a duly organized meeting may continue to do business until adjournment, notwithstanding the withdrawal of enough stockholders or members to leave less than a quorum;

(c) if any necessary officer fails to attend a meeting, any stockholder or member present may be elected to act temporarily in lieu of the absent officer;

(d) if a meeting cannot be held because a quorum is not present, those present may adjourn the meeting to a time that they determine, but in the case of any meeting called for the election of any director, the adjournment must be to the next day and those who attend the second meeting, although less than a quorum as fixed in this section or in the articles of incorporation, constitute a quorum for the purpose of electing any director; and

(e) an annual or special meeting of stockholders or members may be adjourned to another date without new notice being given.

History: En. Sec. 434, Ch. 286, L. 1959; R.C.M. 1947, 40-4717; amd. Sec. 12, Ch. 531, L. 1997; amd. Sec. 31, Ch. 227, L. 2001.

33-3-304. Proxies — corrupt practices. (1) Every proxy of a stockholder of an insurer, unless coupled with an interest, shall be revocable at will and this provision cannot be waived. The validity of every unrevoked proxy shall cease 11 months after the date of its execution unless some other definite period of validity is expressly provided therein, but in no event shall a proxy, unless coupled with an interest, be voted on after 3 years from the date of its execution.

(2) The revocation of a proxy shall not be effective until notice thereof has been given to the secretary of the insurer.

(3) No person shall buy or sell or barter a vote or proxy, relative to any meeting of stockholders or members of an insurer, or engage in any corrupt or dishonest practice in or relative to the conduct of any such meeting.

History: En. Secs. 435, 436, Ch. 286, L. 1959; R.C.M. 1947, 40-4718, 40-4719; amd. Sec. 23, Ch. 396, L. 2017.

33-3-305. Directors — number and election. (1) The affairs of every domestic insurer must be managed by the number of directors fixed in the insurer's bylaws, which may not be less than 5 or more than 21 directors.

(2) Directors must be elected by the members or stockholders of a domestic insurer, except as provided in 33-3-306, at the time and place and for the terms, not exceeding 3 years, as may be provided in the insurer's bylaws. A majority of directors must be elected from the members or stockholders of the domestic insurer.

(3) The term of a director shall extend until a successor has been elected and has qualified.

History: En. Sec. 437, Ch. 286, L. 1959; R.C.M. 1947, 40-4720; amd. Sec. 11, Ch. 451, L. 1993.

33-3-306. Participation of policyholders in election of directors of stock insurer. The bylaws of a domestic stock life insurer may provide a plan for its policyholders to participate with stockholders in the election of its directors.

History: En. Sec. 438, Ch. 286, L. 1959; R.C.M. 1947, 40-4721.

33-3-307. Bonding of officers and employees. (1) When acting in a fiduciary capacity, officers and employees of each mutual insurer or stock insurer shall maintain a fidelity bond issued by an authorized corporate surety in favor of the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in determining the bond amount. In lieu of individual bonds, officers and employees may be covered under a blanket bond for the same respective amounts. The insurer shall file the blanket bond with the commissioner.

(2) The insurer shall pay the premium for the bond.

(3) A bond is not subject to cancellation except upon written notice to both the insurer and the commissioner, delivered not less than 30 days in advance of the effective date of the cancellation.

(4) This section may not be considered to limit the amount of bonded protection that the insurer may carry as to any officer or employee.

(5) The commissioner may adopt rules to determine the bond amount for officers and employees who are subject to the provisions of this section.

History: **En. Sec. 439, Ch. 286, L. 1959; R.C.M. 1947, 40-4722; amd. Sec. 13, Ch. 531, L. 1997; amd. Sec. 18, Ch. 472, L. 1999.**

Cross-References

Suretyship, Title 28, ch. 11, part 4.

33-3-308. Prohibited pecuniary interest of officials. (1) Any officer or director or any member of any committee or an employee of a domestic insurer who is charged with the duty of investing or handling the insurer's funds may not:

(a) deposit or invest the funds except in the insurer's corporate name;

(b) borrow the funds of the insurer;

(c) be pecuniarily interested in any loan, pledge of deposit, security, investment, sale, purchase, exchange, reinsurance, or other similar transaction or property of the insurer except as a stockholder or member;

(d) take or receive to the individual's own use any fee, brokerage, commission, gift, or other consideration for or on account of any transaction made by or on behalf of the insurer.

(2) An insurer may not guarantee any financial obligation of any of its officers or directors.

(3) This section may not prohibit a director or officer or member of a committee or employee from becoming a policyholder of the insurer and enjoying the usual rights provided for its policyholders.

(4) The commissioner may, by regulations from time to time, define and permit additional exceptions to the prohibition contained in subsection (1) solely to enable payment of reasonable compensation to a director who is not otherwise an officer or employee of the insurer or to a corporation or firm in which a director is interested for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of the director or the corporation or firm.

History: **En. Sec. 440, Ch. 286, L. 1959; R.C.M. 1947, 40-4723; amd. Sec. 1136, Ch. 56, L. 2009.**

33-3-309. Management and exclusive agency contracts. (1) A domestic insurer may not make any contract under which any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors or to have the controlling or preemptive right to produce substantially all insurance business for the insurer unless the contract is filed with and approved by the commissioner. The contract must be considered approved unless disapproved by the commissioner within 20 days after date of filing, subject to a reasonable extension of time that the commissioner may require by notice given within 20 days. Any disapproval must be delivered to the insurer in writing, stating the grounds for disapproval.

(2) The commissioner shall disapprove any contract if the commissioner finds that it:

(a) subjects the insurer to excessive charges;

(b) is to extend for an unreasonable length of time;

(c) does not contain fair and adequate standards of performance; or

(d) contains other inequitable provision or provisions that impair the proper interests of stockholders or members of the insurer.

History: **En. Sec. 441, Ch. 286, L. 1959; R.C.M. 1947, 40-4724; amd. Sec. 1137, Ch. 56, L. 2009.**

Cross-References

Hearings by Commissioner, 33-1-701.

33-3-310. Agreement not to sell property prohibited. No insurer shall enter into any agreement to withhold from sale any of its property. Disposition of an insurer's property shall be at all times within the control of its board of directors.

History: **En. Sec. 444, Ch. 286, L. 1959; R.C.M. 1947, 40-4727.**

Part 4
Finance

33-3-401. Home office and records — administrative or civil penalty for unlawful removal of records or assets. (1) Each domestic insurer shall maintain its principal place of business and home office in this state and shall maintain at its principal place of business or home office complete records of its assets, transactions, and affairs in accordance with methods and systems customary or suitable to the kind or kinds of insurance that it transacts. Records of the insurer's operations and other financial records reasonably related to its insurance operations for the preceding 5 years must be maintained and be available to the commissioner or the commissioner's examiner.

(2) Each domestic insurer shall maintain its assets in this state, except for:

(a) real property and appurtenant personal property lawfully owned by the insurer and located outside this state; and

(b) property of the insurer that is customary, necessary, and convenient to enable and facilitate the operation of its branch offices and regional home offices located outside this state as referred to in subsection (4).

(3) Removal of all or a material part of the records or assets of a domestic insurer from this state except pursuant to a plan of merger or consolidation approved by the commissioner under this code or for reasonable purposes and periods of time as may be approved by the commissioner in writing in advance is prohibited. Upon any removal or attempted removal of records or assets or upon retention of records or assets or a material part of the records or assets outside this state beyond the period specified in the commissioner's consent under which the records were removed or upon concealment of or attempt to conceal records or assets in violation of this section, the commissioner may institute delinquency proceedings against the insurer pursuant to the provisions of chapter 2, part 13.

(4) This section does not prohibit or prevent an insurer from:

(a) establishing and maintaining branch offices or regional home offices in other states when necessary or convenient to the transaction of its business and keeping there the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by the out-of-state office, as long as the records and assets are made readily available at that office for examination by the commissioner when requested;

(b) having, depositing, or transmitting funds and assets of the insurer in or to jurisdictions outside of this state as reasonably and customarily required in the regular course of its business;

(c) making deposits under custodial arrangements as provided by 33-2-604(2).

(5) An insurer that fails to maintain records and make them available to the commissioner's staff is subject to the penalties and procedures in 33-1-317, 33-1-318, and 33-2-119.

History: En. Sec. 442, Ch. 286, L. 1959; R.C.M. 1947, 40-4725; amd. Sec. 141, Ch. 575, L. 1981; amd. Sec. 5, Ch. 798, L. 1991; amd. Sec. 5, Ch. 493, L. 2003; amd. Sec. 8, Ch. 169, L. 2013; amd. Sec. 24, Ch. 396, L. 2017.

33-3-402. Vouchers for expenditures. (1) No insurer shall make any disbursement of $100 or more unless evidenced by a voucher correctly describing the consideration for the payment and supported by a check or receipt endorsed or signed by or on behalf of the person receiving the money.

(2) If the disbursement is for services and reimbursement, the voucher shall describe the services and expenditures.

(3) If the disbursement is in connection with any matter pending before any legislature or public body or before any public official, the voucher shall also correctly describe the nature of the matter and of the insurer's interest therein.

(4) If a voucher cannot be obtained, the expenditure referred to in subsection (1) above shall be evidenced by an affidavit in which is set forth the character and object of the expenditure and the reasons for not obtaining a voucher therefor.

History: En. Sec. 443, Ch. 286, L. 1959; R.C.M. 1947, 40-4726.

33-3-403 through 33-3-410 reserved.

33-3-411. Contingent liability of mutual members. (1) Each member of a domestic mutual insurer shall, except as otherwise provided in this part with respect to nonassessable policies, have a contingent liability, pro rata and not one for another, for the discharge of its obligations. The contingent liability must be expressed in the policy and must be in a maximum amount specified in the insurer's articles of incorporation.

(2) Termination of the policy of any member may not relieve the member of contingent liability for the member's proportion, if any, of the obligations of the insurer that accrued while the policy was in force.

(3) Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of its financial condition.

History: En. Sec. 446, Ch. 286, L. 1959; R.C.M. 1947, 40-4729; amd. Sec. 1138, Ch. 56, L. 2009.

33-3-412. Levy of contingent liability. (1) If at any time the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required to be maintained by it by this code for authority to transact the kinds of insurance being transacted and the deficiency is not cured from other sources, its directors shall levy an assessment only upon its members who held policies providing for contingent liability at any time within the 12 months preceding the date notice of the assessment was mailed to them, and the members are liable to the insurer for the amount assessed.

(2) The assessment must be for an amount that is required to cure the deficiency and to provide a reasonable amount of working funds in excess of the minimum amount of surplus, but the working funds provided may not exceed 5% of the insurer's liabilities as of the date that the amount of the deficiency was determined.

(3) In levying an assessment upon a policy providing for contingent liability, the assessment must be computed on the basis of the premiums earned on the policy during the period to which the assessment relates.

(4) A member may not have an offset against any assessment for which the member is liable on account of any claim for unearned premium or loss payable.

(5) As to life insurance, any part of an assessment upon a member that remains unpaid following notice of assessment, demand for payment, and lapse of a reasonable waiting period as specified in the notice may, if approved by the commissioner as being in the best interests of the insurer and its members, be secured by placing a lien upon the cash surrender values and accumulated dividends held by the insurer to the credit of the member.

History: En. Sec. 447, Ch. 286, L. 1959; R.C.M. 1947, 40-4730; amd. Sec. 1139, Ch. 56, L. 2009.

33-3-413. Enforcement of contingent liability. (1) Any assessment made by an insurer under 33-3-412 or 33-3-433 shall be deemed to be prima facie correct. The amount of such assessment to be paid by each member as determined by the insurer shall be deemed to be likewise prima facie correct.

(2) The insurer shall notify each member of the amount of the assessment to be paid by written notice mailed to the address of the member last of record with the insurer. Failure of the member to receive the notice so mailed, within the time specified therein for the payment of the assessment or at all, shall be no defense in any action to collect the assessment.

(3) If a member fails to pay the assessment within the period specified in the notice, which period shall not be less than 20 days after mailing, the insurer may institute suit to collect the same.

History: En. Sec. 448, Ch. 286, L. 1959; R.C.M. 1947, 40-4731.

33-3-414. Nonassessable policies of mutual insurers. (1) While possessing surplus funds in amount not less than the paid-in capital stock required of a domestic stock insurer transacting like kinds of insurance, a domestic mutual insurer may, upon receipt of the commissioner's order so authorizing, extinguish the contingent liability of its members as to all its policies in force and may omit provisions imposing contingent liability in all its policies currently issued.

(2) A foreign or alien mutual insurer may issue nonassessable policies to its members in this state pursuant to its articles of incorporation and the laws of its domicile.

(3) No policy of a domestic mutual insurer which, pursuant to the commissioner's order, is without contingent liability and thereby nonassessable by its terms shall be subject to assessment for any debt or liability of the insurer.

History: En. Sec. 449, Ch. 286, L. 1959; R.C.M. 1947, 40-4732.

33-3-415. Insufficient reserves — nonassessable policies prohibited — revocation of authority. The commissioner shall revoke the authority of a domestic mutual insurer to issue policies without contingent liability if at any time the insurer's assets are less than the sum of its liabilities and the surplus required for such authority or if the insurer, by resolution of its board of directors approved by a majority of its members, requests that the authority be revoked. During the absence of such authority the insurer shall not issue any policy without providing therein for the contingent liability of the policyholder or renew any policy which is renewable at the option of the insurer without endorsing the same to provide for such contingent liability.

History: En. Sec. 450, Ch. 286, L. 1959; R.C.M. 1947, 40-4733.

33-3-416 through 33-3-420 reserved.

33-3-421. Participating policies. (1) If provided in its articles of incorporation, a domestic stock or domestic mutual insurer may issue any or all of its policies with or without participation in profits, savings, or unabsorbed portions of premiums, may classify policies issued on a participating and nonparticipating basis, and may determine the right to participate and the extent of participation of any class or classes of policies. Any such classification or determination shall be reasonable and shall not unfairly discriminate as between policyholders within the same such classifications. A life insurer may issue both participating and nonparticipating policies only if the right or absence of right to participate is reasonably related to the premium charged. Any such domestic insurer which prior to January 1, 1961, has been issuing all or part of its policies on a participating basis without specific authorization in its articles of incorporation may continue to issue such policies on a basis not inconsistent with this section.

(2) After the third policy year no dividend otherwise earned shall be made contingent upon the payment of renewal premium on any policy.

History: En. Sec. 451, Ch. 286, L. 1959; R.C.M. 1947, 40-4734.

33-3-422. Dividends to stockholders. (1) A domestic stock insurer shall not pay any cash dividend to stockholders except out of that part of its available surplus funds which is derived from realized net profits on its business.

(2) A stock dividend may be paid out of any available surplus funds in excess of the aggregate amount of surplus loaned to the insurer under 33-3-431.

(3) A dividend otherwise proper may be payable out of the insurer's earned surplus even though its total surplus is then less than the aggregate of its past contributed surplus resulting from issuance of its capital stock at a price in excess of the par value thereof.

History: En. Sec. 452, Ch. 286, L. 1959; R.C.M. 1947, 40-4735.

33-3-423. Dividends to mutual policyholders. (1) The directors of a domestic mutual insurer may from time to time apportion and pay or credit to its members dividends only out of that part of its surplus funds which represents net realized savings and net realized earnings in excess of the surplus required by law to be maintained.

(2) A dividend otherwise proper may be payable out of such savings and earnings even though the insurer's total surplus is then less than the aggregate of its contributed surplus.

History: En. Sec. 453, Ch. 286, L. 1959; R.C.M. 1947, 40-4736.

33-3-424. Illegal dividends — administrative or civil penalty. (1) Any director of a domestic stock or mutual insurer who votes for or concurs in declaration or payment of a dividend to stockholders or members other than as authorized under 33-3-422 or 33-3-423 shall be jointly and severally liable, together with other such directors likewise voting for or concurring, for any loss thereby sustained by the insurer.

(2) Any stockholder receiving such an illegal dividend shall be liable in the amount thereof to the insurer.

(3) The commissioner may revoke or suspend the certificate of authority of an insurer which has declared or paid such an illegal dividend.

History: En. Sec. 454, Ch. 286, L. 1959; R.C.M. 1947, 40-4737; amd. Sec. 25, Ch. 396, L. 2017.

Cross-References

Revocation or suspension of certificate of authority, 33-2-118, 33-2-119.
Misdemeanor — penalty, 46-18-212.

33-3-425 through 33-3-430 reserved.

33-3-431. Borrowed surplus. (1) A domestic stock or mutual insurer may borrow money to defray the expenses of the insurer's organization, to provide the insurer with surplus funds, or for any purpose of the insurer's business upon a written agreement that the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest at a rate not to exceed the greater of the rate established in 25-9-205 or a rate that is 6 percentage points per year higher than the prime rate published by the federal reserve system in its statistical release H.15 Selected Interest Rates for bank prime loans dated 3 business days prior to the execution of the agreement. The agreement must specify whether the interest constitutes a liability of the insurer. A commission or promotion expense may not be paid in connection with a loan of the type described in this section.

(2) Money borrowed, together with the interest if stipulated in the agreement, does not form a part of the insurer's legal liabilities except as to the insurer's surplus in excess of the amount stipulated in the agreement or the basis of any setoff. However, until the money or interest, or both, are repaid, financial statements filed or published by the insurer must show as a footnote the amount then unpaid together with any interest accrued but unpaid.

(3) A loan of this type to a mutual or stock insurer is subject to the commissioner's approval. The insurer shall, in advance of the loan, file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement are approved unless within 15 days after filing the insurer is notified of the commissioner's disapproval and reasons for the disapproval. The commissioner shall disapprove any proposed loan or agreement if the commissioner finds the loan is unnecessary or excessive for the purpose intended or that the terms of the loan agreement are not fair and equitable to the parties, and to other similar lenders, if any, to the insurer, or that the information filed by the insurer is inadequate.

(4) A loan to a mutual or stock insurer or a substantial portion of the loan must be repaid by the insurer when the loan is no longer reasonably necessary for the purpose originally intended. Repayment of either principal or interest on the loan may not be made by a mutual or stock insurer unless approved in advance by the commissioner.

(5) This section does not apply to loans obtained by the insurer in the ordinary course of business from banks and other financial institutions or to loans secured by pledge or mortgage of assets.

History: En. Sec. 455, Ch. 286, L. 1959; R.C.M. 1947, 40-4738; amd. Sec. 6, Ch. 798, L. 1991; amd. Sec. 34, Ch. 379, L. 1995; amd. Sec. 6, Ch. 469, L. 2005; amd. Sec. 3, Ch. 108, L. 2011.

Cross-References

Hearings by Commissioner, 33-1-701.

33-3-432. Impairment of capital or assets. (1) If a stock insurer's capital, as represented by the aggregate par value of its outstanding capital stock, becomes impaired or the assets of a mutual insurer are less than its liabilities and the minimum amount of surplus required to be maintained by it under 33-3-204 for authority to transact the kinds of insurance being transacted, the commissioner shall at once determine the amount of deficiency and serve notice upon the insurer to make good the deficiency within 60 days after service of such notice.

(2) The deficiency may be made good in cash or in assets eligible under chapter 12 for the investment of the insurer's funds as follows:

(a) if a stock insurer, by reduction of the insurer's capital to an amount not below the minimum required for the kinds of insurance to be transacted; or

(b) if a mutual insurer, by amendment of its certificate of authority to cover only the kind or kinds of insurance for which the insurer has sufficient surplus under this title.

(3) If the deficiency is not made good and proof is filed with the commissioner within the 60-day period, the insurer is insolvent and the commissioner shall institute delinquency proceedings against it under chapter 2, part 13; except that if the deficiency exists because of increased loss reserves required by the commissioner or because of disallowance by the commissioner of certain assets or reduction of the value at which carried in the insurer's accounts, the commissioner may, upon application and good cause shown, extend for not more than an additional 60 days the period within which the deficiency may be made good and proof of making good is filed.

History: **En. Sec. 456, Ch. 286, L. 1959; R.C.M. 1947, 40-4739; amd. Sec. 12, Ch. 303, L. 1981; amd. Sec. 141, Ch. 575, L. 1981; amd. Sec. 44, Ch. 304, L. 1999.**

33-3-433. Assessment of stockholders or members. (1) Any insurer receiving the commissioner's notice mentioned in 33-3-432(1):

(a) if a stock insurer, by resolution of its board of directors and subject to any limitations upon assessment contained in its articles of incorporation, may assess its stockholders for amounts necessary to cure the deficiency and provide the insurer with a reasonable amount of surplus in addition. If a stockholder fails to pay a lawful assessment after notice given to the stockholder in person or by advertisement in a time and manner approved by the commissioner, the insurer may require the return of the original certificate of stock held by the stockholder and in cancellation and in lieu of the original certificate issue a new certificate for the number of shares that the stockholder may then be entitled to, upon the basis of the stockholder's proportionate interest in the amount of the insurer's capital stock as determined by the commissioner to be remaining at the time of determination of the amount of impairment under 33-3-432, after deducting from the proportionate interest the amount of the unpaid assessment. The insurer may pay for or reissue fractional shares under this subsection.

(b) if a mutual insurer, shall levy such an assessment upon members as is provided for under 33-3-412.

(2) Neither 33-3-432 nor this section may be considered to prohibit the insurer from curing any deficiency through any lawful means other than those referred to in 33-3-432 or this section.

History: **En. Sec. 457, Ch. 286, L. 1959; R.C.M. 1947, 40-4740; amd. Sec. 1140, Ch. 56, L. 2009.**

33-3-434. Directors' liability for losses during deficiency. The directors of the insurer shall be individually liable as to losses incurred under policies issued by the insurer after expiration of the period provided in 33-3-432 for curing any deficiency of the insurer's capital stock or surplus and prior to the curing of the deficiency.

History: **En. Sec. 458, Ch. 286, L. 1959; R.C.M. 1947, 40-4741.**

33-3-435. Stock transfer during impairment of capital. Any transfer of the stock of a domestic insurer made during the existence of any impairment of such insurer's capital does not release the stockholder making the transfer from any liability as a stockholder of such insurer which accrued prior to such transfer.

History: **En. Sec. 459, Ch. 286, L. 1959; R.C.M. 1947, 40-4742.**

33-3-436. Mutual member's share of assets on liquidation. (1) Upon any liquidation of a domestic mutual insurer, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, and expenses of administration must be distributed to existing persons who were its members at any time within 36 months preceding the date that liquidation was authorized or ordered or the date of last termination of the insurer's certificate of authority, whichever date is the earlier.

(2) The distributive share of each member under subsection (1) must be in the proportion that the aggregate premiums earned by the insurer on the policies of the member during the combined periods of membership bear to the aggregate of all premiums earned on the policies of all members. The insurer may, and if the insurer is a life insurer shall, make a reasonable classification of its policies held by members and a formula based upon the classification for determining the equitable distributive share of each member. The classification and formula are subject to the approval of the commissioner.

History: **En. Sec. 466, Ch. 286, L. 1959; R.C.M. 1947, 40-4749; amd. Sec. 1141, Ch. 56, L. 2009.**

33-3-437 through 33-3-440 reserved.

33-3-441. Equity securities of domestic stock insurance company — statement of ownership. (1) When used in 33-3-441 through 33-3-447, the term "equity security" means:

(a) any stock or similar security;

(b) any security convertible, with or without consideration, into an equity security or carrying any warrant or right to subscribe to or purchase an equity security;

(c) any warrant or right described in subsection (1)(b); or

(d) any other security that the commissioner considers to be of a similar nature and considers necessary or appropriate, by rules as the commissioner may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(2) A domestic stock insurance company shall report to the commissioner the name of any person who acquires 10% or more of any class of equity security of the company. The company shall report the name of the person within 30 days of the person acquiring 10% or more of any class of equity security of the company. The company shall provide any other information about the person that the commissioner may require.

(3) If a person has not acquired at least a 10% interest of any class of equity security of a domestic stock insurance company during the last calendar year preceding the annual statement filing date, the company is only required to report in the annual statement the names and percentages of those persons holding at least 10% interest in any class of equity security.

History: En. Secs. 1, 6, Ch. 159, L. 1965; R.C.M. 1947, 40-4751, 40-4756; amd. Sec. 14, Ch. 380, L. 2003.

33-3-442. Inside trading of securities — profit inures to company — limitation of action to recover — rules. (1) For the purpose of preventing the unfair use of information that may have been obtained by the beneficial owner, director, or officer by reason of the individual's relationship to the company, any profit realized by the individual from any purchase and sale, or any sale and purchase, of any equity security of the company within any period of less than 6 months, unless the security was acquired in good faith in connection with a debt previously contracted, must benefit and be recoverable by the company, irrespective of any intention on the part of the beneficial owner, director, or officer in entering into the transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding 6 months.

(2) Suit to recover the profit described in subsection (1) may be instituted at law or in equity in any court of competent jurisdiction by the company or by the owner of any security of the company in the name and in behalf of the company if the company fails or refuses to bring suit within 60 days after request or fails to diligently prosecute the suit. However, the suit may not be brought more than 2 years after the date the profit was realized.

(3) This section may not be construed to cover any transaction in which the beneficial owner was not the beneficial owner both at the time of the purchase and sale, or the sale and purchase, of the security involved or any transaction or transactions that the commissioner may exempt by rule as not comprehended within the purpose of this section.

History: En. Sec. 2, Ch. 159, L. 1965; R.C.M. 1947, 40-4752; amd. Sec. 1142, Ch. 56, L. 2009.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.
Promulgation of rules, 33-1-313.

33-3-443. Short sales of equity securities prohibited — time for delivery after sale. (1) It is unlawful for any beneficial owner, director, or officer, directly or indirectly, to sell any equity security of the company if the person selling the security or the person's principal:

(a) does not own the security sold; or

(b) if the person owns the security, does not deliver it against the sale within 20 days or does not within 5 days after the sale deposit it in the mail or other usual channels of transportation.

(2) A person may not be considered to have violated this section if the person proves that notwithstanding the exercise of good faith the person was unable to make the delivery or deposit within that time or that to do so would cause undue inconvenience or expense.

History: En. Sec. 3, Ch. 159, L. 1965; R.C.M. 1947, 40-4753; amd. Sec. 1143, Ch. 56, L. 2009.

33-3-444. Exemptions — securities held in an investment account — primary or secondary market — rules. (1) The provisions of 33-3-442 do not apply to any purchase and sale, or sale and purchase, and the provisions of 33-3-443 do not apply to any sale of an equity security of a domestic stock insurance company not then or later held by a person in an investment account by a broker-dealer in the ordinary course of business and incident to the establishment or maintenance by the broker-dealer of a primary or secondary market, except on an exchange as defined in the Securities Exchange Act of 1934, for the security.

(2) The commissioner may, by rules that the commissioner considers necessary or appropriate in the public interest, define and prescribe terms and conditions with respect

to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

History: En. Sec. 4, Ch. 159, L. 1965; R.C.M. 1947, 40-4754; amd. Sec. 1144, Ch. 56, L. 2009.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-3-445. Exemptions — arbitrage transactions. The provisions of 33-3-441 through 33-3-443 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules as the commissioner may adopt in order to carry out the purposes of 33-3-441 through 33-3-447.

History: En. Sec. 5, Ch. 159, L. 1965; R.C.M. 1947, 40-4755.

33-3-446. Exemptions — registered securities — holding by less than 100 persons. The provisions of 33-3-441 through 33-3-443 shall not apply to equity securities of a domestic stock insurance company if:

(1) such securities shall be registered or shall be required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934, as amended; or

(2) such domestic stock insurance company shall not have any class of its equity securities held of record by 100 or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of 33-3-441 through 33-3-443 except for the provisions of this subsection (2).

History: En. Sec. 7, Ch. 159, L. 1965; R.C.M. 1947, 40-4757.

Cross-References

Securities regulation — registration, Title 30, ch. 10, part 2.

33-3-447. Rules of commissioner — classifications — effect. (1) The commissioner may adopt rules that may be necessary for the execution of the functions vested in the commissioner by 33-3-441 through 33-3-446 and may classify domestic stock insurance companies, securities, and other persons or matters within the commissioner's jurisdiction.

(2) A provision of 33-3-441 through 33-3-443 imposing any liability does not apply to any act done or omitted in good faith in conformity with any rule of the commissioner, notwithstanding that the rule may, after the act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

History: En. Sec. 8, Ch. 159, L. 1965; R.C.M. 1947, 40-4758; amd. Sec. 1145, Ch. 56, L. 2009.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.
Promulgation of rules, 33-1-313.

33-3-448 and 33-3-449 reserved.

33-3-450. Purpose. The purpose of 33-3-450 through 33-3-453 is to authorize domestic insurance companies to utilize modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate rules adopted by the commissioner.

History: En. Sec. 1, Ch. 380, L. 2003.

33-3-451. Definitions. As used in this chapter, the following definitions apply:

(1) "Clearing corporation" has the meaning provided in 30-8-112, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business in the foreign country, a clearing corporation may include a corporation that is organized or existing under the laws of any foreign country and is legally qualified under those laws to effect transactions in securities by computerized book entry.

(2) "Direct participant" means a bank, trust company, or other institution that maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(3) "Federal reserve book-entry system" means the computerized systems sponsored by the United States department of the treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and those agencies and instrumentalities, respectively, in federal reserve banks through banks that are members of the federal reserve system or that otherwise have access to the computerized systems.

(4) "Member bank" means a national bank, state bank, or trust company that is a member of the federal reserve system and through which an insurance company participates in the federal reserve book-entry system.

(5) "Security" has the meaning provided in 30-8-112.

History: **En. Sec. 2, Ch. 380, L. 2003.**

33-3-452. Use of book-entry systems — rules. (1) (a) Other provisions of law may not be construed as prohibiting a domestic insurance company from depositing or arranging for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the federal reserve book-entry system.

(b) When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of the clearing corporation with any other securities deposited with the clearing corporation by any person, regardless of the ownership of the securities. Certificates representing securities of small denominations may be merged into one or more certificates of larger denominations.

(c) The records of any member bank through which an insurance company holds securities in the federal reserve book-entry system and the records of any custodian bank through which an insurance company holds securities in a clearing corporation at all times must show that the securities are held for the insurance company and for which accounts of the insurance company.

(d) Ownership and other interests in securities subject to this subsection (1) may be transferred by bookkeeping entry on the books of a clearing corporation or in the federal reserve book-entry system without, in either case, physical delivery of certificates representing the securities.

(2) The commissioner may adopt rules that include but are not limited to rules governing the deposit by insurance companies of securities with clearing corporations and in the federal reserve book-entry system and rules pertaining to evidence that must be provided to the commissioner with respect to the recording of securities.

History: **En. Sec. 3, Ch. 380, L. 2003.**

33-3-453. Deposit of securities by insurance companies. (1) Securities qualified for deposit under 33-3-450 through 33-3-453 may be deposited with a clearing corporation or held in the federal reserve book-entry system.

(2) An insurance company that is using securities to help meet the deposit requirements of Title 33, chapter 2, parts 1 and 6, and depositing those securities with a clearing corporation or holding the securities in the federal reserve book-entry system:

(a) may not withdraw the securities without the approval of the commissioner; and

(b) shall provide to the commissioner evidence issued by its custodian or member bank through which the insurance company has deposited the securities in a clearing corporation or through which the securities are held in the federal reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian, other direct participant, or member bank and that the records of the custodian, other direct participant, or member bank reflect that the securities are held subject to the order of the commissioner.

History: **En. Sec. 4, Ch. 380, L. 2003; amd. Sec. 11, Ch. 151, L. 2017.**

Part 5
Insurance Operations

33-3-501. Repealed. Sec. 29, Ch. 303, L. 1981.

History: **En. Sec. 430, Ch. 286, L. 1959; R.C.M. 1947, 40-4713.**

33-3-502. Solicitations in other states. (1) A domestic insurer may not knowingly solicit insurance business in any reciprocating state in which it is not then licensed as an authorized insurer.

(2) This section does not prohibit advertising through publication and radio, television, and other broadcasts originating outside the reciprocating state if the insurer is licensed in a majority of the states in which the advertising is disseminated and if the advertising is not specifically directed to residents of the reciprocating state.

(3) This section does not prohibit insurance, covering persons or risks located in a reciprocating state, under contracts solicited and issued in states in which the insurer is then licensed. This section does not prohibit insurance effectuated by the insurer as an unauthorized insurer in accordance with the laws of the reciprocating state.

(4) A reciprocating state, as used in this section, is one under the laws of which a similar prohibition is imposed upon and enforced against insurers domiciled in that state.

(5) The commissioner shall suspend or revoke the certificate of authority of a domestic insurer found by the commissioner, after a hearing, to have violated this section.

History: **En. Sec. 445, Ch. 286, L. 1959; R.C.M. 1947, 40-4728; amd. Sec. 1146, Ch. 56, L. 2009.**

Cross-References

Hearings by Commissioner, 33-1-701.

Revocation or suspension of certificate of authority, 33-2-118.

33-3-503. Membership in mutuals. (1) Each policyholder of a domestic mutual insurer, other than of a reinsurance contract, is a member of the insurer with all rights and obligations of such membership, and the policy shall so specify.

(2) Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, firm, estate, trustee, or fiduciary may be a member of a domestic, foreign, or alien mutual insurer. Any officer, stockholder, trustee, or legal representative of any such corporation, board, association, or estate may be recognized as acting for or on its behalf for the purpose of such membership and shall not be personally liable upon any contract of insurance for acting in such representative capacity.

(3) Any domestic corporation may participate as a member of a mutual insurer as an incidental purpose for which such corporation is organized and as much granted as the rights and powers expressly conferred.

History: **En. Sec. 431, Ch. 286, L. 1959; R.C.M. 1947, 40-4714.**

Part 6
Dissolution and Liquidation

Part Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.

33-3-601. Voluntary dissolution of domestic insurers — plan of dissolution. (1) At least 60 days before a domestic stock insurer or a for-profit domestic mutual insurer submits a proposed voluntary dissolution to shareholders or policyholders under 35-14-1402 or voluntarily dissolves under 35-14-1401, the insurer shall file the plan for dissolution with the commissioner. The commissioner may require the submission of additional information to establish the financial condition of the insurer or other facts relevant to the proposed dissolution. If the shareholders or policyholders adopt the resolution to dissolve, the commissioner shall, within 30 days after the adoption of the resolution, begin to examine the insurer. The commissioner shall approve the dissolution unless, after a hearing, the commissioner finds the insurer is insolvent or may become insolvent in the process of dissolution. If the commissioner approves the voluntary dissolution, the insurer may dissolve under 35-14-1401 through 35-14-1409. The papers required by 35-14-1401 through 35-14-1404 to be filed with the secretary of state must instead be filed with the commissioner. The duties required by 35-14-125 to be performed by the secretary of state must instead be performed by the commissioner. If the commissioner does not approve the voluntary dissolution, the commissioner shall petition the court for liquidation or rehabilitation under Title 33, chapter 2, part 13.

(2) At least 60 days before a nonprofit domestic mutual insurer submits a proposed voluntary dissolution to the board or members under 35-2-721 or voluntarily dissolves under 35-2-720, the insurer shall file the plan for dissolution with the commissioner. The commissioner may require the submission of additional information to establish the financial condition of the insurer or other facts relevant to the proposed dissolution. If the board or members adopt the resolution to dissolve, the commissioner shall, within 30 days after the adoption of the resolution, begin to examine the insurer. The commissioner shall approve the dissolution unless, after a hearing, the commissioner finds the insurer is insolvent or may become insolvent in the process of dissolution. If the commissioner approves the voluntary dissolution, the insurer may dissolve under Title 35, chapter 2, part 7, except that 35-2-728(1)(d) does not apply. The papers required

by 35-2-720 through 35-2-725 to be filed with the secretary of state must instead be filed with the commissioner. The duties required by 35-2-119 to be performed by the secretary of state must instead be performed by the commissioner. If the commissioner does not approve the voluntary dissolution, the commissioner shall petition the court for liquidation or rehabilitation under Title 33, chapter 2, part 13.

History: En. Sec. 2, Ch. 389, L. 1987; amd. Sec. 189, Ch. 368, L. 1991; amd. Sec. 12, Ch. 151, L. 2017; amd. Sec. 9, Ch. 62, L. 2019; amd. Sec. 233, Ch. 271, L. 2019.

33-3-602. Conversion to involuntary liquidation. An insurer may at any time during liquidation under Title 35, chapter 2, part 7, or Title 35, chapter 14, part 14, apply to the commissioner to have the liquidation continued under the commissioner's supervision. Upon receipt of the application, the commissioner shall apply to the court for liquidation under 33-2-1341.

History: En. Sec. 3, Ch. 389, L. 1987; amd. Sec. 190, Ch. 368, L. 1991; amd. Sec. 1147, Ch. 56, L. 2009; amd. Sec. 13, Ch. 151, L. 2017; amd. Sec. 234, Ch. 271, L. 2019.

33-3-603. Revocation of voluntary dissolution. If an insurer revokes the voluntary dissolution proceedings under 35-2-724 or 35-14-1404, the insurer shall file a copy of the revocation of voluntary dissolution proceedings with the commissioner.

History: En. Sec. 4, Ch. 389, L. 1987; amd. Sec. 191, Ch. 368, L. 1991; amd. Sec. 14, Ch. 151, L. 2017; amd. Sec. 235, Ch. 271, L. 2019.

33-3-604. Distribution of assets of mutual insurer. The maximum amount that a mutual insurer may pay to a policyholder upon dissolution, in addition to the benefits promised in the insurance policy, is the total of the premium payments made by the policyholder with interest at the legal rate compounded annually. Any excess over the amounts must be deposited with the state treasurer to the credit of the state general fund. A person may participate in the distribution of assets of a mutual insurer only if the person has a policy in effect 180 days before the insurer files its plan for dissolution with the commissioner. The amount that a person eligible to participate in the distribution of assets of a mutual insurer may receive must be in the proportion that the premiums paid by the policyholder bear to the total premiums paid to the mutual insurer by all policyholders who had policies in effect 180 days before the insurer filed its plan for dissolution with the commissioner.

History: En. Sec. 5, Ch. 389, L. 1987; amd. Sec. 1148, Ch. 56, L. 2009.

Part 7
Disclosure of Material Transactions

33-3-701. Short title. This part may be cited as the "Disclosure of Material Transactions Act".

History: En. Sec. 78, Ch. 379, L. 1995.

33-3-702. Report. (1) An insurer domiciled in this state shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations, or revisions have been submitted to the commissioner for review or approval or for information purposes pursuant to other provisions of the insurance code, laws, or regulations or other requirements.

(2) The report required in subsection (1) is due within 15 days after the end of the calendar month in which any of the transactions in subsection (1) occur.

(3) One complete copy of the report, including any exhibits or other attachments, must be filed with:

(a) the insurance department of the state in which the insurer is domiciled; and

(b) the national association of insurance commissioners.

(4) All reports obtained by or disclosed to the commissioner pursuant to this part must be treated confidentially, may not be subject to subpoena, and may not be made public by the commissioner, the national association of insurance commissioners, or any other person, except to insurance departments of other states, without the prior consent of the insurer to which it pertains unless the commissioner, after giving the insurer notice and an opportunity to be

heard, determines that the interest of policyholders, shareholders, or the public will be served by publication, in which event the commissioner may publish all or any part of the report in the manner the commissioner chooses.

History: **En. Sec. 79, Ch. 379, L. 1995.**

33-3-703. Acquisitions and dispositions of assets. (1) Acquisitions or dispositions of assets that are not material are not required to be reported pursuant to 33-3-702 if the acquisitions or dispositions are not material. For purposes of this part, a material acquisition or the aggregate of any series of related acquisitions during any 30-day period or a disposition or the aggregate of any series of related dispositions during any 30-day period is one that is nonrecurring and not in the ordinary course of business and involves more than 5% of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(2) Asset acquisitions subject to this part include every purchase, lease, exchange, merger, consolidation, succession, or other acquisition, other than the construction or development of real property, by or for the reporting insurer or the acquisition of materials for this purpose.

(3) Asset dispositions subject to this part include each sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment, whether for the benefit of creditors or otherwise, abandonment, destruction, or other disposition.

(4) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(a) the date of the transaction;

(b) the manner of acquisition or disposition;

(c) the description of the assets involved;

(d) the nature and amount of the consideration given or received;

(e) the purpose or reason for the transaction;

(f) the manner by which the amount of consideration was determined;

(g) the gain or loss recognized or realized as a result of the transaction; and

(h) the names of the persons from whom the assets were acquired or to whom they were disposed.

(5) An insurer is required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer cedes substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

History: **En. Sec. 80, Ch. 379, L. 1995.**

33-3-704. Nonrenewals, cancellations, or revisions of ceded reinsurance agreements. (1) A nonrenewal, cancellation, or revision of a ceded reinsurance agreement need not be reported pursuant to 33-3-702 if the nonrenewal, cancellation, or revision is not material. For purposes of this part, a material nonrenewal, cancellation, or revision is one that affects:

(a) property and casualty business, including disability business written by a property and casualty insurer, so that:

(i) more than 50% of the insurer's total ceded written premium is affected; or

(ii) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves are affected;

(b) life, annuity, and disability business, so that more than 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement is affected;

(c) either property and casualty or life, annuity, and disability business and causes either of the following events that constitutes a material revision that must be reported:

(i) an authorized reinsurer representing more than 10% of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than 10% of a total cession.

(2) However, a filing is not required if:

(a) with respect to property and casualty business, including disability business written by a property and casualty insurer, the insurer's total ceded written premium represents, on an annualized basis, less than 10% of its total written premium for direct and assumed business; or

(b) with respect to life, annuity, and disability business, the total reserve credit taken for business ceded represents, on an annualized basis, less than 10% of the statutory reserve requirement prior to any cession.

(3) The following information is required to be disclosed in any report of a material nonrenewal, cancellation, or revision of ceded reinsurance agreements:

(a) the effective date of the nonrenewal, cancellation, or revision;

(b) the description of the transaction with an identification of the initiator of the transaction;

(c) the purpose or reason for the transaction; and

(d) if applicable, the identity of the replacement reinsurers.

(4) Insurers are required to report all material nonrenewals, cancellations, or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers that uses a pooling arrangement or 100% reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is considered to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than $1 million total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than 5% of the insurer's capital and surplus.

History: En. Sec. 81, Ch. 379, L. 1995.

CHAPTER 4
FARM MUTUAL INSURERS

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Part 1
General Provisions

33-4-101. Scope of chapter — provisions applicable. (1) The chapter applies to:

(a) all domestic mutual hail, fire, and other casualty insurers of farm property and stock and rural buildings formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections 40-1501 through 40-1517 of the Revised Codes of Montana, 1947;

(b) all domestic mutual rural insurers formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections 40-1601 through 40-1625 of the Revised Codes of Montana, 1947;

(c) all insurers formed under this chapter.

(2) The insurance laws of this state do not apply to or govern, either directly or indirectly, domestic farm mutual insurers except as provided in this chapter.

(3) The following chapters and sections of this title apply to farm mutual insurers to the extent applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of the express provisions of this chapter: chapter 1, parts 1 through 4, 7, 12, and 13; 33-2-112; 33-2-501; 33-2-502; 33-2-708; 33-2-1212; chapter 2, parts 13 and 16; 33-2-1501; 33-2-1517(2); 33-3-218; 33-3-308; 33-3-309; 33-3-401; 33-3-402; 33-3-431; 33-3-436; chapter 3, part 6; and chapters 18 and 19.

History: En. Secs. 468, 520, Ch. 286, L. 1959; R.C.M. 1947, 40-4801, 40-4853; amd. Sec. 141, Ch. 575, L. 1981; amd. Sec. 12, Ch. 451, L. 1993; amd. Sec. 1, Ch. 158, L. 1997; amd. Sec. 19, Ch. 472, L. 1999; amd. Sec. 32, Ch. 227, L. 2001; amd. Sec. 15, Ch. 380, L. 2003; amd. Sec. 7, Ch. 469, L. 2005; amd. Sec. 11, Ch. 63, L. 2015.

Cross-References

Board of Hail Insurance — powers and duties, 2-15-3003; Title 80, ch. 2, part 2.

33-4-102. Definitions. (1) A "county mutual insurer" is a farm mutual insurer authorized to insure property and liability risks located in the county in which its principal office is located and in the counties in this state with boundaries contiguous with the principal office county.

(2) A "farm mutual insurer" is an insurer that meets the qualifications of 33-4-101(1).

(3) A "state mutual insurer" is a farm mutual insurer authorized to insure property and liability risks throughout the state.

(4) "Surplus" is the extent to which the value of an insurer's assets exceeds its liabilities.

History: En. Secs. 469, 481, Ch. 286, L. 1959; R.C.M. 1947, 40-4802, 40-4814; amd. Sec. 2, Ch. 158, L. 1997.

33-4-103. Corporate powers in general. (1) An insurance corporation formed under this chapter or existing on January 1, 1961, and of a type which might be formed under this chapter shall have the same capacity to act possessed by individuals but with authority to perform only such lawful acts as are necessary or proper to accomplish its purposes.

(2) Without affecting the authority contained in subsection (1) above, every such corporation shall have the following corporate powers:

(a) to have succession by its corporate name for the period stated in its articles;

(b) to sue and be sued in its corporate name;

(c) to adopt, use, and alter a corporate seal;

(d) to acquire, hold, sell, use, dispose of, pledge, or mortgage any such property as its purpose may require, subject to any limitation prescribed by law or the articles of incorporation;

(e) to transact insurance;

(f) to conduct its affairs through its directors, officers, employees, insurance producers, and representatives thereunto duly authorized;

(g) to make bylaws not inconsistent with law for the exercise of its corporate powers, the management, regulation, and government of its affairs and property, including but not limited to calling and holding of meetings of its directors or members, and to modify or amend such bylaws;

(h) to exercise, subject to law and the express provisions of the articles of incorporation, all such incidental and subsidiary powers as may be necessary or convenient to the attainment of the objectives set forth in such articles;

(i) to dissolve and wind up or be dissolved and wound up in the manner provided by law.

(3) An insurance corporation formed under this chapter may also form a subsidiary entity for the purpose of acting as an insurance producer, transacting insurance underwritten by other insurers. The subsidiary entity shall comply with the licensing requirements of chapter 17, as well as all other laws that apply to insurance producers. Funds used by an insurance corporation formed under this chapter for a subsidiary entity insurance producer are considered investments but are exempt from the requirements of 33-4-403.

History: En. Sec. 479, Ch. 286, L. 1959; R.C.M. 1947, 40-4812; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 15, Ch. 151, L. 2017.

Part 2
Formation

33-4-201. Eligible incorporators. (1) One hundred or more individuals residing in this state, each of whom is 18 years of age or more, who collectively own farm property as referred to in 33-4-501(1)(a) valued at not less than $500,000 which they desire to insure, and each of whom owns farm lands or ranch lands situated in this state valued at not less than $5,000, may incorporate a state mutual insurer.

(2) Twenty-five or more individuals residing in this state, each of whom is 18 years or more of age, each of whom owns farm land or ranch land valued at $5,000 or more in the county wherein is to be located the principal office of the proposed insurer or in any county in this state contiguous with such county, and who collectively own in such counties farm property referred to in 33-4-501(1)(a) valued at not less than $125,000 which they desire to insure, may incorporate a county mutual insurer.

History: En. Sec. 474, Ch. 286, L. 1959; amd. Sec. 8, Ch. 423, L. 1971; R.C.M. 1947, 40-4807.

33-4-202. Declaration of intention to incorporate — articles of incorporation. (1) The individuals proposing to form a farm mutual insurer as referred to in 33-4-201 shall file with the commissioner:

(a) a declaration of their intention to form the corporation signed by at least 100 persons if a proposed state mutual insurer or by at least 25 persons if a proposed county mutual insurer; and

(b) proposed articles of incorporation executed by three or more incorporators. The signatures of the incorporators must be notarized.

(2) The articles of incorporation must state:

(a) the name of the corporation. If a state mutual insurer, the words "farm mutual" must be a part of the name; if a county mutual insurer, the name must contain the words "farm mutual" or "rural mutual" together with the name of the county in which its principal place of business is to be located. The name may not be so similar to one already used by a corporation in this state as to be misleading.

(b) if a county mutual insurer, the name of the county or counties in which the corporation is to transact insurance and the address where its principal business office will be located;

(c) if a state mutual insurer, the location of its principal business office, which must be located in this state;

(d) the objects and purposes for which the corporation is formed;

(e) whether the insurer intends to transact business on the cash premium plan or the assessment plan;

(f) the duration of the corporation's existence, which may be perpetual;

(g) the number of its directors, which may not be less than 5 or more than 11, and the names and addresses of the members of the initial board of directors appointed to manage the affairs of the corporation until the first annual meeting of the members at which time successors must be elected and qualified;

(h) other provisions, not inconsistent with law, considered appropriate by the incorporators;

(i) the names, residences, and addresses of the persons signing the declaration under subsection (1)(a) and the value of their property to be insured in the county or counties where the operations of the corporation are to be transacted.

History: En. Sec. 475, Ch. 286, L. 1959; R.C.M. 1947, 40-4808; amd. Sec. 35, Ch. 379, L. 1995; amd. Sec. 14, Ch. 531, L. 1997; amd. Sec. 16, Ch. 380, L. 2003; amd. Sec. 6, Ch. 117, L. 2019.

33-4-203. Approval of articles — commencement of corporate existence. (1) If the commissioner finds the proposed articles of incorporation to be in accordance with the provisions of this chapter and not in conflict with the constitution and laws of the United States or of this state, the articles must be approved. The commissioner shall forward the approved articles and the applicable fees to the secretary of state.

(2) If the commissioner considers the name of the proposed corporation to be so similar to one already appropriated by another company or corporation as to be likely to mislead the public, the commissioner shall reject the name applied for and shall notify the incorporators of the rejection.

(3) The corporation has legal existence upon the issuance of the certificate of incorporation by the secretary of state, but it may not transact business as an insurer until it has obtained a certificate of authority as provided in 33-4-505.

History: En. Sec. 476, Ch. 286, L. 1959; R.C.M. 1947, 40-4809; amd. Sec. 13, Ch. 451, L. 1993; amd. Sec. 36, Ch. 379, L. 1995; amd. Sec. 15, Ch. 531, L. 1997; amd. Sec. 20, Ch. 472, L. 1999; amd. Sec. 7, Ch. 117, L. 2019.

Cross-References

Secretary of State — fee for filing documents, 2-6-1006.

County Clerk — filing fee, 7-4-2631.

33-4-204. Amendment of articles — change of status. (1) A farm mutual insurer may, by a vote of two-thirds of its members present at any annual meeting or at any special meeting called for that purpose, amend its articles of incorporation to extend its corporate duration or any other particular within the scope of this chapter by causing amended articles to be filed in the same form and manner as required for original articles of incorporation.

(2) (a) A county mutual insurer may change its status to that of a state mutual insurer by amending its articles of incorporation pursuant to the requirements of this section.

(b) A county mutual insurer that changes its status to that of a state mutual insurer shall conform with all requirements for a state mutual insurer under this chapter.

(3) (a) A state mutual insurer may change its status to that of a county mutual insurer by amending its articles of incorporation pursuant to this section.

(b) A state mutual insurer that changes its status to that of a county mutual insurer shall conform with all requirements for a county mutual insurer under this chapter.

(4) The commissioner shall review the amended articles for compliance with this title. The amended articles of incorporation may be signed only by the president and secretary of the corporation. Notice of the proposed amendment must be contained in the notice of the annual or special meeting.

History: **En. Sec. 477, Ch. 286, L. 1959; R.C.M. 1947, 40-4810; amd. Sec. 16, Ch. 531, L. 1997; amd. Sec. 1, Ch. 228, L. 2001; amd. Sec. 16, Ch. 151, L. 2017; amd. Sec. 8, Ch. 117, L. 2019.**

33-4-205. Certified copies of articles as evidence. A copy of the articles of incorporation of a farm mutual insurer and any amendments thereof filed pursuant to law and certified by the commissioner shall be received in all courts and other places as prima facie evidence of the facts therein stated and of the due incorporation of the insurer.

History: **En. Sec. 478, Ch. 286, L. 1959; R.C.M. 1947, 40-4811.**

33-4-206. Initial qualifications. When applying for an original certificate of authority as an insurer newly organized in this state or for an amended certificate of authority in the case of a county mutual insurer that is changing its status to that of a state mutual insurer pursuant to 33-4-204, the insurer must have surplus as required by 33-4-401 and be otherwise qualified under this chapter, and:

(1) if a county mutual insurer, it must have received acceptable bona fide written applications from 25 separate persons for substantial insurance of the kinds of insurance proposed to be transacted, aggregating at least $100,000. The applicants must have given to the insurer the obligations referred to in 33-4-508 or paid the premium required for the insurance, subject to the insurer qualifying to transact the kinds of insurance for which it has applied.

(2) if a state mutual insurer or a county mutual insurer that has changed its status to that of a state mutual insurer pursuant to 33-4-204, it must have received acceptable bona fide written applications from 100 separate persons, each for substantial insurance, aggregating at least $500,000 of the kinds of insurance proposed to be transacted. The applicants must have given to the insurer the obligations referred to in 33-4-508 or paid the premium required for the insurance, subject to the insurer qualifying to transact the kinds of insurance for which it has applied.

(3) if to insure growing crops against loss or damage by hail, it must have received applications for hail insurance from not less than 100 persons residing in Montana and owning in the aggregate not less than 5,000 acres of grain. Each applicant must have given to the insurer the obligations referred to in 33-4-508 or paid the premium required for the insurance, subject to the insurer qualifying to transact hail insurance.

History: **En. Sec. 480, Ch. 286, L. 1959; R.C.M. 1947, 40-4813; amd. Sec. 2, Ch. 228, L. 2001.**

Cross-References

State hail insurance, 2-15-3003; Title 80, ch. 2, part 2.
Certificate of authority, 33-4-505.

Part 3
Management

33-4-301. Bylaws — adoption — power to amend. Upon commencement of the legal existence of an insurer, its initial board of directors shall adopt such original bylaws, not inconsistent with the state constitution or this chapter, as may be deemed necessary for the management of its affairs. The bylaws shall be subject to the approval of the insurer's members at their next succeeding meeting. The members shall otherwise have the power to make, modify, and revoke bylaws.

History: **En. Sec. 484, Ch. 286, L. 1959; R.C.M. 1947, 40-4817.**

33-4-302. Bylaws — contents. (1) The bylaws of a farm mutual insurer must provide:

(a) for the liability of each member for payment of the expenses and losses of the insurer and for what obligations must be given for the expenses and losses when a person applies for insurance;

(b) for the time when obligations of members for losses and expenses become due;

(c) for the limitation of liability of members for the payment of expenses and losses of the insurer;

(d) for the terms of office of the directors. At least part of the directors must be elected at each annual meeting of members. The term of any director may not be longer than 3 years.

(e) the month of the annual meeting of the members, at which vacancies existing or occurring on the board of directors are to be filled by election by the members. Each member must be permitted to cast at least one vote, either in person or, if authorized in the bylaws, by proxy, for each director to be elected and may cumulate the member's votes for one or more directors, not exceeding the number to be elected.

(f) how directors are to be elected in case an election does not occur at the annual meeting or in event of resignation, disability, or death of a director;

(g) the manner and time of giving notice of annual and special meetings of members.

(2) The bylaws may provide:

(a) the character of property to be insured and under what restrictions and limitations;

(b) restrictions and limitations as to membership and the powers, duties, and obligations of the members other than as to obligations covered under subsection (1)(a);

(c) the manner of making and collecting assessments;

(d) the manner of the suspension and expulsion of members;

(e) the form of application and the form of policy;

(f) the manner of making proof, adjustment, and payment of losses;

(g) for who is authorized to adjust losses for the insurer;

(h) for arbitration, as provided in 33-4-411, in the event that the insurer's adjuster and any claimant cannot agree as to the amount of any insured damage or loss;

(i) the duties and compensation of the officers and the bonds to be required of them;

(j) the books and records to be kept by the insurer, the reports required of the officers, and the manner of examining and auditing their accounts;

(k) what must be contained on the corporate seal and when the seal is required to be used;

(l) other matters as may be considered necessary or convenient for the management of the affairs of the insurer.

History: En. Sec. 485, Ch. 286, L. 1959; R.C.M. 1947, 40-4818; amd. Sec. 1149, Ch. 56, L. 2009; amd. Sec. 9, Ch. 169, L. 2013.

33-4-303. Bylaws binding upon members. The bylaws of a farm mutual insurer are binding upon all of its members and as from time to time amended are a part of the contracts of insurance between the insurer and its members.

History: En. Sec. 486, Ch. 286, L. 1959; R.C.M. 1947, 40-4819.

33-4-304. Annual meetings of members — where held. Annual meetings of the members of a farm mutual insurer may be held at its principal business office or at any other place located in any county in this state in which the insurer is authorized to transact insurance.

History: En. Sec. 488, Ch. 286, L. 1959; R.C.M. 1947, 40-4821.

33-4-305. Annual meeting — presentation of annual statement. The annual statement of the insurer as required to be filed with the commissioner under 33-4-313 shall be presented at the annual meeting of the members of the insurer next following the end of the calendar year to which such statement relates.

History: En. Sec. 489, Ch. 286, L. 1959; R.C.M. 1947, 40-4822.

33-4-306. Adjourned annual meetings — notice. Notice of any adjourned annual meeting of members shall be given to the members of an insurer in the same manner as provided in the insurer's bylaws for the regular annual meeting of members.

History: En. Sec. 490, Ch. 286, L. 1959; R.C.M. 1947, 40-4823.

33-4-307. Members' voting rights. Each member of an insurer is entitled to one vote upon each matter coming to a vote at meetings of members of the insurer. A member may vote by written proxy if and as may be provided in the insurer's bylaws. No such proxy shall be made irrevocable or for longer than 1 year.

History: En. Sec. 491, Ch. 186, L. 1959; R.C.M. 1947, 40-4824.

33-4-308. Board of directors — quorum. (1) The general management of the affairs of a farm mutual insurer is vested in its board of directors.

(2) A majority of the directors shall constitute a quorum to do business at any lawful meeting of the board.

History: En. Sec. 494, Ch. 286, L. 1959; R.C.M. 1947, 40-4827.

33-4-309. Directors — election and term. (1) Directors of a farm mutual insurer must be elected by its members by ballot or acclamation for terms not to exceed 3 years and hold office until their respective successors are elected and have qualified.

(2) An individual may not serve as a director unless the individual is a member of the insurer.

History: **En. Sec. 495, Ch. 286, L. 1959; R.C.M. 1947, 40-4828; amd. Sec. 11, Ch. 227, L. 2011.**

33-4-310. Officers. The board of directors of an insurer shall elect from their number a president and vice-president. The board shall also elect a secretary and treasurer or a secretary-treasurer, who may or may not be members of the insurer. Officers shall hold their offices for 1 year and until their successors are elected and qualified, unless earlier removed by the board of directors.

History: **En. Sec. 496, Ch. 286, L. 1959; R.C.M. 1947, 40-4829.**

33-4-311. Bonding of officers, managers, and employees. (1) When acting in a fiduciary capacity, officers, managers, and employees shall each give bonds to the insurer for the faithful performance of their duties. The bond must be issued by an authorized corporate surety.

(2) The commissioner may adopt rules to determine the amount of the bonds required under this section.

History: **En. Sec. 497, Ch. 286, L. 1959; R.C.M. 1947, 40-4830; amd. Sec. 21, Ch. 472, L. 1999.**

Cross-References

Surety bonds, Title 28, ch. 11, part 4.
Suretyship, Title 33, ch. 26.

33-4-312. Officers, agents, and employees not licensed — exception for liability insurance. (1) Except as provided in subsection (2), an agent of an insurer is not required to obtain a license or authority from any public official to transact business for the insurer. The insurer or its officers, agents, or employees are not required to pay any fee for a license for the transaction of the business of the insurer, except as provided in this chapter.

(2) A farm mutual insurer that offers liability insurance is required to have an insurance producer licensed by the state of Montana to transact liability insurance. A person may not sell, solicit, negotiate, or take applications for, procure, or place for others liability insurance for a farm mutual insurer unless that person is licensed under Title 33, chapter 17.

History: **En. Sec. 498, Ch. 286, L. 1959; R.C.M. 1947, 40-4831; amd. Sec. 1, Ch. 28, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 3, Ch. 399, L. 2007.**

33-4-313. Annual statement. The president and secretary of each insurer, on or before March 1 each year, shall prepare, affirm under oath, and file with the commissioner, on forms prescribed and furnished by the commissioner, an annual statement for the preceding calendar year showing the condition of the insurer as of December 31 of the preceding year and exhibiting the following facts:

(1) the names of the president and secretary;
(2) the date of the annual meeting;
(3) the amount of insurance in force;
(4) the number of members;
(5) the number of assessments made during the year;
(6) the amount paid in losses during the year;
(7) the number of members withdrawn, suspended, and expelled during the year;
(8) the number of new members admitted during the year;
(9) the expenses during the year;
(10) the amount of money on hand;
(11) the amount and character of the insurer's assets;
(12) the amount of the insurer's liabilities, including any reserves required to be established under this chapter; and
(13) other information concerning the insurer's affairs that the commissioner may reasonably require.

History: **En. Sec. 499, Ch. 286, L. 1959; R.C.M. 1947, 40-4832; amd. Sec. 1, Ch. 337, L. 1987; amd. Sec. 17, Ch. 531, L. 1997; amd. Sec. 22, Ch. 472, L. 1999.**

33-4-314. Annual statement — exclusive report — penalty for failure to file. (1) A report, statement, or return of any nature may not be required of any farm mutual insurer other than those required by 33-4-313.

(2) The commissioner may:

(a) suspend or revoke the certificate of authority of any insurer failing to file its annual statement as required; or

(b) impose a fine of up to $100 a day for each day that an insurer is late in filing its annual statement, with the aggregate penalty not to exceed $1,000.

History: En. Sec. 500, Ch. 286, L. 1959; R.C.M. 1947, 40-4833; amd. Sec. 18, Ch. 531, L. 1997.

Cross-References

Certificate of authority, 33-4-505.

33-4-315. Examination by commissioner — expense. (1) The commissioner has power, at any time, to investigate and examine the affairs and books of any insurer.

(2) The insurer shall pay the costs of investigation and examination by the commissioner in the same manner as prescribed in 33-1-413.

History: En. Sec. 501, Ch. 286, L. 1959; R.C.M. 1947, 40-4834; amd. Sec. 1, Ch. 177, L. 1987.

33-4-316. Records — inspections. (1) A farm mutual insurer, through its president and secretary, shall keep or cause to be kept accurate records and accounts of its transactions. The books, files, and records of the insurer must be located at its principal place of business or, in the case of a county mutual insurer, at a place within the county of its principal place of business as may be designated by the insurer's board of directors and shown in the minutes of the board.

(2) The books, files, and records of the insurer must be available for inspection by the insurer's directors and officers and by the commissioner or the commissioner's duly constituted examiner at all reasonable times.

History: En. Sec. 508, Ch. 286, L. 1959; R.C.M. 1947, 40-4841; amd. Sec. 1150, Ch. 56, L. 2009.

33-4-317 through 33-4-319 reserved.

33-4-320. Managing general agent waiver — exceptions. (1) The commissioner may waive the requirements for a managing general agent under Title 33, chapter 2, part 16, for a person managing the property and liability business of a resident domestic farm mutual insurer.

(2) The commissioner may revoke the waiver if the commissioner determines through examination that licensure of the person as a managing general agent is necessary.

(3) A person serving as a managing general agent for crop hail insurance may not receive a waiver under this section.

History: En. Sec. 1, Ch. 208, L. 2013.

Part 4
Finance

33-4-401. Surplus funds required. A domestic farm mutual insurer is authorized to transact insurance if it is otherwise in compliance with the applicable provisions of this chapter and if it maintains surplus funds as follows:

(1) if a state mutual insurer or a county mutual insurer that has changed its status to that of a state mutual insurer pursuant to the provisions of 33-4-204, surplus of not less than $200,000; or

(2) if a county mutual insurer, surplus of not less than $50,000.

History: En. Sec. 482, Ch. 286, L. 1959; R.C.M. 1947, 40-4815; amd. Sec. 3, Ch. 228, L. 2001.

33-4-402. Members' liability — limitation. All liability of the members of a farm mutual insurer must be as limited in the insurer's bylaws. For insurers transacting business on the cash premium plan, the limitation must comply with 33-4-504(4). A member may not be required to pay more than the full amount of the member's obligation given to the insurer or of the member's liability as provided for in the bylaws.

History: En. Sec. 492, Ch. 286, L. 1959; R.C.M. 1947, 40-4825; amd. Sec. 1151, Ch. 56, L. 2009.

33-4-403. Investments. (1) When directed by a majority vote of its members present at a meeting of members, the directors of a farm mutual insurer may invest the insurer's funds or any part of the funds in any of the following:

(a) bonds or other securities issued by the United States government or by any agency of the United States;

(b) bonds or other obligations the payment of the interest and principal of which is assumed or guaranteed by the United States government or any agency of the United States;

(c) general obligation bonds or warrants of any state, county, or city, when approved by the commissioner;

(d) loans secured by a first mortgage on real estate situated in the state of Montana but subject to the provisions of subsection (3);

(e) common stock of a domestic insurer formed as an affiliate company to two or more farm mutual insurers for the purpose of offering companion insurance products that farm mutual insurers are prohibited from selling. The investment may not exceed one-third of the assets of the farm mutual insurer.

(f) corporate bonds that are rated A3 or better by Moody's investor service, inc., or A- or better by Standard and Poor's corporation and that are issued with the full credit of the parent corporation. An investment in corporate bonds may not exceed 20% of the total assets of the mutual insurer, and no more than 5% of the total assets of the mutual insurer may be invested with one corporation.

(g) money market funds as defined by rules adopted by the commissioner. An investment in money market funds may not exceed 20% of the total assets of the mutual insurer, and no more than 5% of the total assets of the mutual insurer may be invested in a single money market fund.

(2) At the time of making an investment the document evidencing the investment must be stamped with the name of the insurer with the following notation printed or written on the document: "Negotiable only upon the order of the Board of Directors of .... (naming the insurer)."

(3) A real estate loan may not be for more than 60% of the appraised value of the real estate securing the loan, and the appraisal must have been made within 30 days prior to the date of the loan. The loan may not be for a term longer than 10 years. This subsection does not prevent the renewal or extension of loans already made and does not apply to real estate loans that are insured under the provisions of any act of the congress of the United States or to the making, extension, or renewal of any loans that are made under subchapter II of the act of congress known as the "Servicemen's Readjustment Act of 1944", or any amendment thereof or supplement thereto, as to any part of the loans. This subsection does not prevent an insurer from taking another and immediately subsequent mortgage or deed of trust when it already holds a first mortgage or deed of trust on the same real estate or from accepting a second lien on real estate to secure the payment of a debt previously contracted in good faith. This subsection does not prevent subsequent liens of any kind from being taken to secure the payment of a debt previously contracted in good faith when in the judgment of the insurer's board of directors the subsequent liens are necessary to further secure the payment of any debts and save the insurer from loss.

History: En. Sec. 502, Ch. 286, L. 1959; R.C.M. 1947, 40-4835; amd. Sec. 6, Ch. 274, L. 1981; amd. Sec. 145, Ch. 575, L. 1981; amd. Exec. Ord. No. 16-81; amd. Sec. 1, Ch. 77, L. 1983; amd. Sec. 1, Ch. 334, L. 1993.

Cross-References

Restrictive endorsements — negotiable instruments, 30-3-205.

33-4-404. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 503, Ch. 286, L. 1959; R.C.M. 1947, 40-4836.

33-4-405. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 504, Ch. 286, L. 1959; R.C.M. 1947, 40-4837.

33-4-406. Reserves — cash premium plan. Each insurer transacting business on the cash premium plan shall maintain the following reserves:

(1) a loss reserve, in amount reasonably adequate to pay in full all losses already incurred but currently unpaid. The amount subsequently paid on such losses shall be credited against this reserve.

(2) a reserve for unearned premiums, which reserve shall be computed at 50% of net premiums (gross premiums less premiums returned) charged and collected for unexpired policy periods that commenced during the calendar year covered by the financial statement plus 100%

of such net premiums charged and collected in advance for policy periods that are to commence after such calendar year. In the alternative, the insurer may at its option compute its entire reserve for unearned premiums as the aggregate amount of the pro rata unearned premiums for each policy in force as at the end of the calendar year to be covered by the financial statement.

History: **En. Sec. 505, Ch. 286, L. 1959; R.C.M. 1947, 40-4838.**

33-4-407. Profits or dividends. An insurer may not accumulate any profits or pay any dividends. This provision does not prohibit an insurer from accumulating and maintaining surplus funds as required to be maintained by the insurer under this chapter or from accumulating and maintaining other voluntary reserves for purposes and in amounts that may be reasonable. Limitations on any accumulations and the purposes of the accumulations may be provided for in the insurer's bylaws.

History: **En. Sec. 506, Ch. 286, L. 1959; R.C.M. 1947, 40-4839; amd. Sec. 33, Ch. 227, L. 2001.**

33-4-408. Deficiency of surplus. (1) If the surplus funds of a farm mutual insurer at any time fall below the amount required to be maintained under this chapter, the insurer shall cure such deficiency within 6 months thereafter, notwithstanding that new losses or expenses may be incurred within such 6-month period.

(2) If the deficiency is not so cured, the commissioner may, upon the insurer's written application therefor, allow an additional reasonable period, not to exceed 6 months, for the curing of the deficiency.

(3) If the deficiency is not so cured within the first 6-month period, if additional time is not so applied for, or within such additional period as the commissioner may so allow, the commissioner shall forthwith suspend or revoke the insurer's certificate of authority.

History: **En. Sec. 507, Ch. 286, L. 1959; R.C.M. 1947, 40-4840.**

Cross-References

Certificate of authority, 33-4-505.

33-4-409. Repealed. Sec. 44, Ch. 531, L. 1997.

History: **En. Sec. 509, Ch. 286, L. 1959; R.C.M. 1947, 40-4842; amd. Sec. 2, Ch. 177, L. 1987; amd. Sec. 1, Ch. 327, L. 1987.**

33-4-410. Losses — notice — adjustment. (1) Every member of a domestic farm mutual insurer who has sustained any insured loss or damage shall immediately notify the insurer's secretary thereof and of the amount of damage or loss claimed.

(2) Upon receipt of the notice of loss referred to in subsection (1) above, the secretary shall notify the person or persons authorized by the bylaws of such insurer to ascertain the amount of the loss or damage and adjust the same.

History: **En. Sec. 514, Ch. 286, L. 1959; R.C.M. 1947, 40-4847.**

33-4-411. Arbitration — committee — compensation. (1) If any insurer's adjuster and a claimant fail to agree as to the amount of the insured loss or damage sustained by the claimant and if provided for in the insurer's bylaws, the matter must be submitted to three persons as a committee of reference. One member must be selected by the claimant, one by the insurer, and the third by the other two members, all of whom must be sworn to a faithful and impartial investigation and award.

(2) The committee of reference has authority to examine witnesses and determine all matters in dispute. The decision or award of the committee must be made in writing to the secretary of the insurer. If it relates to any claimed loss or damage to a crop, the decision or award may not be made until after maturity of the crop. The decision or award of the committee is final and binding upon all parties unless an interested party appeals to the court within 30 days after the decision or award.

(3) The compensation of each member of any committee must be at the rate of $10 per day for each day of service in the discharge of duties. The compensation must be paid by the claimant unless the award of the committee exceeds the sum offered by the insurer in settlement of the claim, in which case the compensation must be paid by the insurer.

History: **En. Sec. 515, Ch. 286, L. 1959; R.C.M. 1947, 40-4848; amd. Sec. 1152, Ch. 56, L. 2009.**

Cross-References

Uniform Arbitration Act, Title 27, ch. 5.

33-4-412. Obligations or assessments due — losses payable. (1) Obligations or assessments of members for losses and expenses become due and payable at such time as may be provided in the bylaws of the insurer, and the insurer shall use due diligence to collect each obligation or assessment.

(2) Any valid claim for an insured loss against an insurer transacting business on the assessment plan shall not be payable by the insurer until 30 days after such obligations of the members are due and payable.

History: En. Sec. 516, Ch. 286, L. 1959; R.C.M. 1947, 40-4849.

33-4-413. Suit to collect obligations — liability of directors or officers. (1) An insurer may institute a suit against any member of such insurer if the member fails to pay when due any obligation or liability of the member given such insurer under the provisions of this chapter.

(2) The directors or officers of an insurer are liable in their individual capacity to the person sustaining an insured loss if they willfully refuse or neglect to perform the duties imposed upon them by the provisions of this section.

History: En. Sec. 517, Ch. 286, L. 1959; R.C.M. 1947, 40-4850.

33-4-414. Proportionate payment of losses. If the aggregate whole amount of the members' obligations to an insurer transacting business on the assessment plan are insufficient to pay all valid claims for losses under the insurer's contracts of insurance after necessary expenses in any one year, then such claimants insured by the insurer shall receive their proportionate share of the funds realized from such obligations in full satisfaction of such losses.

History: En. Sec. 518, Ch. 286, L. 1959; R.C.M. 1947, 40-4851.

33-4-415. Suit to collect for loss. If the insurer fails to pay any insured loss when due, an action may be maintained against it to collect for such loss, but subject to 33-4-414 as to assessment plan insurers.

History: En. Sec. 519, Ch. 286, L. 1959; R.C.M. 1947, 40-4852.

Part 5
Insurance Operations

33-4-501. Insuring powers in general. (1) In respect to property insurance as defined in 33-1-210, a farm mutual insurer shall insure against loss or damage by fire or other casualty only:

(a) rural dwellings and buildings, including the usual contents, farm livestock, machinery, vehicles, growing crops, and other forms of farm property owned by a member of the insurer or by the member's spouse;

(b) residential dwellings, appurtenant structures, and personal property owned by a member of the insurer or by the member's spouse;

(c) dwellings and related buildings designed for occupancy by not over four families, together with the usual contents;

(d) rural schoolhouses and buildings used in connection with the schoolhouse, rural community houses, rural churches, or other rural public buildings.

(2) A farm mutual insurer may insure against the liability risks provided in 33-1-206(1)(b):

(a) only to the extent of the limit of risks provided in 33-4-502(3); and

(b) if contingent liability exists, provided that every policy contains a statement that each member of the farm mutual insurer is subject to a contingent liability under 33-3-411.

History: En. Sec. 470, Ch. 286, L. 1959; R.C.M. 1947, 40-4803; amd. Sec. 2, Ch. 28, L. 1987; amd. Sec. 2, Ch. 334, L. 1993; amd. Sec. 1, Ch. 281, L. 1995; amd. Sec. 4, Ch. 228, L. 2001.

33-4-502. Limit of risk — retention of liability. (1) Except as provided in subsection (3), the maximum amount of insurance that an insurer may retain on a single risk, after deduction of applicable reinsurance, may not exceed the greater of 10% of the admitted assets of the insurer or $50,000.

(2) For the purposes of this section, a "single risk" as to insurance against fire and hazards other than windstorm, earthquake, or other catastrophic perils includes all properties insured by the same insurer that are reasonably susceptible to loss or damage from the same fire or the same occurrence of another hazard insured against.

(3) A farm mutual insurer:

(a) that insures any portion of a liability risk shall maintain a surplus of at least $50,000;

(b) that retains any portion of a liability risk shall obtain reinsurance on that liability insurance with an insurer that meets the criteria established in 33-4-503. A farm mutual insurer's retention on a single liability risk may not exceed the greater of 3% of admitted assets or $50,000.

(c) may not retain liability risk or risk resulting from insuring growing crops against loss or damage from hail or other hazards greater than the proportional share of each limit of liability in the following schedule:

Surplus as of the Preceding December 31:	Proportional Share of Each Limit of Liability Retained:
$1,000,000 or greater	15%
$800,000 to $999,999	12%
$600,000 to $799,999	9%
$400,000 to $599,999	6%
$200,000 to $399,999	3%
Under $200,000	0%

History: En. Sec. 471, Ch. 286, L. 1959; amd. Sec. 1, Ch. 259, L. 1967; amd. Sec. 1, Ch. 94, L. 1975; R.C.M. 1947, 40-4804; amd. Sec. 1, Ch. 319, L. 1979; amd. Sec. 1, Ch. 132, L. 1981; amd. Sec. 3, Ch. 28, L. 1987; amd. Sec. 3, Ch. 158, L. 1997; amd. Sec. 6, Ch. 271, L. 2009; amd. Sec. 3, Ch. 208, L. 2013.

33-4-503. Reinsurance. A farm mutual insurer may cede reinsurance to any other farm mutual insurer or insurers and to other authorized property insurers and reinsurers meeting the requirements of 33-2-1216 and may accept reinsurance from other farm mutual insurers.

History: En. Sec. 472, Ch. 286, L. 1959; R.C.M. 1947, 40-4805; amd. Sec. 8, Ch. 469, L. 2005; amd. Sec. 7, Ch. 271, L. 2009.

Cross-References

Reinsurance — general provisions, Title 33, ch. 2, part 12.

33-4-504. Cash premium or assessment plans. (1) An insurer may transact business either on a cash premium plan or on an assessment plan, depending upon which plan is provided for in its articles of incorporation or bylaws.

(2) If transacting business on the cash premium plan, the insurer shall collect from each member a premium in cash in an amount that the insurer considers adequate to cover losses and expenses incurred during the term of the insurance.

(3) If transacting business on the assessment plan, the insurer shall principally depend for the payment of losses and expenses upon assessments from time to time levied upon members either before or after any losses or expenses have been incurred. This provision may not be construed as preventing any insurer from collecting from each member an initial amount that the insurer considers proper prior to or at the time of the effectuation of the member's insurance, and this provision may not be considered to prohibit the acquisition, accumulation, and maintenance of surplus or unallocated funds.

(4) An insurer transacting business on the cash premium plan may provide in its bylaws and policies for special assessment of its members if the cash premium charged is found by the insurer to be inadequate to pay in full losses and expenses currently incurred. The bylaws must provide a specific limitation on the amount that can be assessed in any one policy year, and the amount may not be less than one or more than six times the premium charged on each member's policy at the annual rate for a term of 1 year.

History: En. Sec. 473, Ch. 286, L. 1959; R.C.M. 1947, 40-4806; amd. Sec. 8, Ch. 271, L. 2009.

33-4-505. Certificate of authority required — issuance — continuation — fee. (1) A farm mutual insurer may not insure any risk in this state unless it then holds a subsisting certificate of authority issued to it by the commissioner.

(2) Upon application, the commissioner shall issue a certificate of authority to every insurer qualified under this chapter.

(3) Every certificate of authority continues in force as long as the farm mutual insurer is entitled under this chapter and until suspended, revoked, or otherwise terminated; subject,

however, to continuance of the certificate by the farm mutual insurer each year by payment before May 15 of the continuation fee of $10 if a county mutual insurer or $25 if a state mutual insurer, to be deposited by the commissioner with the state treasurer to the credit of the state general fund.

(4) If the farm mutual insurer does not continue its certificate of authority in accordance with subsection (3), its certificate of authority expires at midnight on May 31 next following its failure to continue it in force. The commissioner shall promptly notify a farm mutual insurer that has not continued its certificate of authority of the impending expiration of its certificate of authority.

(5) A certificate of authority is subject to suspension or revocation by the commissioner for violation of or noncompliance with any provision of this chapter or referred to in this chapter.

(6) The commissioner may reinstate a certificate of authority that a farm mutual insurer has inadvertently permitted to expire, after the farm mutual insurer has fully cured all failures that resulted in the expiration and upon payment by the farm mutual insurer of the current continuation fee as provided in subsection (3). If a certificate is not reinstated, the commissioner may grant a farm mutual insurer another certificate of authority only after the farm mutual insurer files an application for a certificate of authority and meets all other requirements for an original certificate of authority in this state.

(7) The commissioner may amend a certificate of authority at any time to accord with changes in the farm mutual insurer's charter of insuring powers.

History: En. Sec. 483, Ch. 286, L. 1959; R.C.M. 1947, 40-4816; amd. Sec. 2, Ch. 327, L. 1987; amd. Sec. 7, Ch. 316, L. 1999.

Cross-References

Contested case administrative hearings, 2-4-102.

33-4-506. Members — minimum membership. (1) A person may not become a member of a farm mutual insurer except by insuring property owned by the person insurable under this chapter.

(2) The membership of an insurer consists of the persons lawfully insuring in the insurer.

(3) The total membership of the insurer must at all times be not less than the number of persons required by 33-4-201 to incorporate an insurer.

History: En. Sec. 487, Ch. 286, L. 1959; R.C.M. 1947, 40-4820; amd. Sec. 1153, Ch. 56, L. 2009.

33-4-507. Withdrawal of member — cancellation by insurer. (1) A member of an insurer may withdraw by surrendering the member's policy to the insurer for cancellation and paying all obligations then owed by the member to the insurer.

(2) The insurer may cancel the policy of any member for any cause considered adequate by the insurer and upon not less than 10 days' written notice in advance of cancellation delivered to the member or mailed to the member's last address of record on file with the insurer.

History: En. Sec. 493, Ch. 286, L. 1959; R.C.M. 1947, 40-4826; amd. Sec. 1154, Ch. 56, L. 2009.

33-4-508. Application for insurance. A person desiring insurance shall make written application to the insurer. If the insurer is transacting business on the assessment plan, the applicant shall at the time of application give the applicant's obligation to the insurer for the payment of losses and expenses as provided in the insurer's bylaws and make advance payment in cash as the insurer may require.

History: En. Sec. 510, Ch. 286, L. 1959; R.C.M. 1947, 40-4843; amd. Sec. 1155, Ch. 56, L. 2009.

33-4-509. Application and policy forms filed with commissioner. All forms of application for insurance and of policies proposed to be used by an insurer must be filed with and approved by the commissioner prior to the issuance, delivery, or use in this state. The commissioner shall disapprove any form found by the commissioner to be unlawful, illegible, or misleading. An insurer may not use any form after it has received the commissioner's notice of disapproval setting forth the reasons for disapproval.

History: En. Sec. 511, Ch. 286, L. 1959; R.C.M. 1947, 40-4844; amd. Sec. 1156, Ch. 56, L. 2009; amd. Sec. 12, Ch. 157, L. 2023.

Cross-References

Contested case administrative proceedings, 2-4-102.

33-4-510. Rates — filing — discrimination. (1) A farm mutual insurer is not required to file any of its insurance rates with the commissioner. No such rate shall be unfairly discriminatory as between subjects of insurance covered for like perils under like policies and having substantially the same insuring, exposure, and underwriting characteristics.

(2) Notwithstanding any provision of subsection (1) or chapter 18, part 2, of this title, a farm mutual insurer transacting insurance under this chapter may refuse to renew a casualty or liability policy upon nonpayment of dues to the farm mutual insurer if payment of dues is a condition for obtaining or continuing such insurance.

History: **En. Sec. 512, Ch. 286, L. 1959; R.C.M. 1947, 40-4845; amd. Sec. 1, Ch. 319, L. 1981.**

33-4-511. Insurance of schools, community houses, and churches. (1) A contract of insurance effected upon the property of any school district, rural community house, rural church, or rural public building pursuant to 33-4-501 does not constitute the school district or the owners of the community house, church, or public building a member of the insurer.

(2) A contract of insurance effected upon any rural school building, rural community house, rural church, or other rural public building referred to in 33-4-501(1)(d) is not invalid because the directors or any director or officer of the insurer at the time of effecting the insurance coverage was a trustee, director, insurance producer, custodian, or manager or in any way in control, supervision, or management of any or all of the property insured.

History: **En. Sec. 513, Ch. 286, L. 1959; R.C.M. 1947, 40-4846; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 144, Ch. 42, L. 1997.**

33-4-512 through 33-4-520 reserved.

33-4-521. Farm mutual insurers — merger. (1) A domestic farm mutual insurer may not merge or consolidate with a stock insurer.

(2) A domestic farm mutual insurer may merge or consolidate with another farm mutual insurer or another domestic mutual insurer if:

(a) the insurers transact similar lines of business;

(b) the insurers agree on a plan for merger or consolidation which must be submitted to all members of each insurer by ballot and approved by two-thirds of the members voting for each respective insurer; and

(c) after submitting the plan for review and opportunity for a hearing, the commissioner provides written approval or denial of the merger or consolidation within a reasonable time.

(3) After opportunity for a hearing in subsection (2), the commissioner may not approve the merger or consolidation if evidence shows that it:

(a) is inequitable to the policyholders of any domestic mutual insurer involved;

(b) would substantially reduce the security of and service to be rendered to policyholders of the domestic mutual insurer; or

(c) is contrary to law.

(4) Sections 33-3-217(5) and 33-3-218 also apply to mergers and consolidations of mutual insurers with farm mutual insurers.

(5) Upon merger or consolidation of a domestic farm mutual insurer with another domestic mutual insurer under this chapter, the corporate charter of the merged or consolidated domestic farm mutual insurer must automatically be extinguished and nullified.

History: **En. Sec. 1, Ch. 184, L. 2015.**

33-4-522. Bulk reinsurance — farm mutual insurers. (1) A domestic farm mutual insurer may reinsure all or substantially all its business in force, or all or substantially all of a major class of its business, with another insurer, stock or mutual, by an agreement of bulk reinsurance after compliance with this section. An agreement may not become effective unless filed with the commissioner and approved by the commissioner in writing.

(2) The commissioner shall approve an agreement within a reasonable time after filing if the commissioner finds it to be fair and equitable to each domestic insurer involved and that the reinsurance if effectuated would not substantially reduce the protection or service to its policyholders. If the commissioner does not approve the agreement, the commissioner shall notify each insurer involved in writing specifying the reasons for disapproval.

(3) The plan and agreement for reinsurance must be approved by a quorum of the board of directors of each farm mutual insurer involved in the agreement.

History: **En. Sec. 2, Ch. 184, L. 2015.**

CHAPTER 5
RECIPROCAL INSURERS

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33-5-502. Certificate of authority.
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Part 1
General Provisions

33-5-101. Scope of chapter — existing insurers. (1) All authorized reciprocal insurers shall be governed by those sections of this chapter not expressly made applicable to domestic reciprocals.

(2) Existing authorized reciprocal insurers shall after January 1, 1961, comply with the provisions of this chapter and shall make such amendments to their subscribers' agreement, power of attorney, policies, and other documents and accounts and perform such other acts as may be required for such compliance.

History: En. Sec. 540, Ch. 286, L. 1959; R.C.M. 1947, 40-5003.

33-5-102. Definitions. (1) "Reciprocal insurance" is that resulting from an interexchange among persons, known as "subscribers", of reciprocal agreements of indemnity, the interexchange being effectuated through an attorney-in-fact common to all such persons.

(2) A "reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact to provide reciprocal insurance among themselves.

History: En. Secs. 538, 539, Ch. 286, L. 1959; R.C.M. 1947, 40-5001, 40-5002.

Cross-References

Indemnity, Title 28, ch. 11, part 3.

33-5-103. Name — suits. A reciprocal insurer shall:

(1) have and use a business name. The name shall include the word "reciprocal", "interinsurer", "interinsurance", "exchange", "underwriters", or "underwriting".

(2) sue and be sued in its own name.

History: **En. Sec. 542, Ch. 286, L. 1959; R.C.M. 1947, 40-5005.**

33-5-104. Attorney — not doing business. (1) "Attorney", as used in this chapter, refers to the attorney-in-fact of a reciprocal insurer. The attorney may be an individual, firm, or corporation.

(2) The attorney of a foreign or alien reciprocal insurer, which insurer is duly authorized to transact insurance in this state, shall not, by virtue of discharge of its duties as such attorney with respect to the insurer's transactions in this state, be thereby deemed to be doing business in this state within the meaning of any laws of this state applying to foreign firms or corporations.

History: **En. Sec. 543, Ch. 286, L. 1959; R.C.M. 1947, 40-5006.**

Part 2
Formation

33-5-201. Organization of reciprocal insurer. (1) (a) Twenty-five or more persons domiciled in this state may organize a domestic reciprocal insurer and apply to the commissioner for a certificate of authority to transact insurance.

(b) Eight or more employers with a total of more than 500 employees may organize a domestic reciprocal insurer and apply to the commissioner for a certificate of authority to transact insurance for the purpose of providing workers' compensation coverage for their employees.

(2) The proposed attorney shall file with the commissioner when applying for a certificate of authority a declaration setting forth:

(a) the name of the insurer;

(b) the location of the insurer's principal office, which must be the same as that of the attorney and must be maintained within this state;

(c) the kinds of insurance proposed to be transacted, which in the case of a reciprocal insurer organized pursuant to subsection (1)(b) may only be workers' compensation coverage for employees;

(d) the names and addresses of the original subscribers;

(e) the designation and appointment of the proposed attorney and a copy of the power of attorney;

(f) the names and addresses of the officers and directors of the attorney, if a corporation, or its members, if a firm;

(g) the powers of the subscribers' advisory committee and the names and terms of office of the members of the committee;

(h) that all money paid to the reciprocal insurer must, after deducting any sum payable to the attorney, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;

(i) a copy of the subscribers' agreement;

(j) a statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted and that the insurer has received from each subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than 6 months at an adequate rate filed with and approved by the commissioner;

(k) a statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by 33-5-401 is on hand; and

(l) a copy of each policy, endorsement, and application form proposed for issue or use.

(3) The declaration must be acknowledged by the attorney in the manner required for the acknowledgment of deeds.

History: **En. Sec. 545, Ch. 286, L. 1959; R.C.M. 1947, 40-5008; amd. Sec. 15, Ch. 198, L. 1979; amd. Sec. 1, Ch. 500, L. 2003.**

Cross-References

Certificate of authority, 33-5-502.

33-5-202. Merger or conversion. (1) A domestic reciprocal insurer, upon affirmative vote of not less than two-thirds of its subscribers who vote on a merger pursuant to due notice and the approval of the commissioner of the terms, may merge with another reciprocal insurer or be converted to a stock or mutual insurer.

(2) A stock or mutual insurer is subject to the same capital or surplus requirements and has the same rights as a similar domestic insurer transacting the same kinds of insurance.

(3) The commissioner may not approve any plan for merger or conversion that is inequitable to subscribers or that, if for conversion to a stock insurer, does not give each subscriber a preferential right to acquire stock of the proposed insurer proportionate to the subscriber's interest in the reciprocal insurer as determined in accordance with 33-5-411 and a reasonable length of time within which to exercise the right.

History: En. Sec. 564, Ch. 286, L. 1959; R.C.M. 1947, 40-5027; amd. Sec. 1157, Ch. 56, L. 2009.

Cross-References

Contested case administrative proceedings, 2-4-102.
Hearings by Commissioner, 33-1-313.

Part 3
Management

33-5-301. Power of attorney. (1) The rights and powers of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

(2) The power of attorney must set forth:

(a) the powers of the attorney;

(b) that the attorney is empowered to accept service of process on behalf of the insurer in actions against the insurer upon contracts exchanged;

(c) the general services to be performed by the attorney;

(d) the maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense in addition to losses to be paid by the insurer; and

(e) except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount, which amount shall be not less than 1 or more than 10 times the premium or premium deposit stated in the policy.

(3) The power of attorney may:

(a) provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(b) impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

(c) provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(d) contain other lawful provisions deemed advisable.

(4) The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement shall be used or be effective as to a domestic reciprocal insurer until approved by the commissioner.

History: En. Sec. 547, Ch. 286, L. 1959; R.C.M. 1947, 40-5010.

Cross-References

Power of attorney — agency generally, Title 28, ch. 10.

33-5-302. Modifications. Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No such modification shall be effective retroactively or as to any insurance contract issued prior thereto.

History: En. Sec. 548, Ch. 286, L. 1959; R.C.M. 1947, 40-5011.

33-5-303. Attorney's bond. (1) Concurrently with the filing of the declaration provided for in 33-5-201, the attorney of a domestic reciprocal insurer shall file with the commissioner a bond in favor of this state for the benefit of all persons damaged as a result of breach by the attorney of the conditions of the attorney's bond as set forth in subsection (2). The bond must be executed by the attorney and by an authorized corporate surety and must be subject to the commissioner's approval.

(2) The bond must be in the penal sum of $25,000, aggregate in form, conditioned that the attorney will faithfully account for all money and other property of the insurer coming into the attorney's possession and that the attorney will not withdraw or appropriate to the attorney's own use from the funds of the insurer any money or property to which the attorney is not entitled under the power of attorney.

(3) The bond must provide that it is not subject to cancellation unless 30 days' advance notice in writing of cancellation is given to both the attorney and the commissioner.

History: En. Sec. 549, Ch. 286, L. 1959; R.C.M. 1947, 40-5012; amd. Sec. 1158, Ch. 56, L. 2009.

Cross-References

Surety bonds, Title 28, ch. 11, part 4.
Suretyship, Title 33, ch. 26.

33-5-304. Action on bond. Action on the attorney's bond or to recover against any such deposit made in lieu thereof may be brought at any time by one or more subscribers suffering loss through a violation of its conditions or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety shall be limited to the amount of the penalty of such bond.

History: En. Sec. 550, Ch. 286, L. 1959; R.C.M. 1947, 40-5013.

33-5-305. Subscribers' advisory committee — duties. (1) The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under such rules as the subscribers adopt.

(2) Not less than two-thirds of such committee shall be subscribers other than the attorney or any person employed by, representing, or having a financial interest in the attorney.

(3) The committee shall:

(a) supervise the finances of the insurer;

(b) supervise the insurer's operations to such extent as to assure conformity with the subscribers' agreement and power of attorney;

(c) procure the audit of the accounts and records of the insurer and of the attorney at the expense of the insurer; and

(d) have such additional powers and functions as may be conferred by the subscribers' agreement.

History: En. Sec. 555, Ch. 286, L. 1959; R.C.M. 1947, 40-5018.

Part 4
Finance

33-5-401. Surplus funds required. (1) A domestic reciprocal insurer subject to this part, if it has otherwise complied with the applicable provisions of this code, may be authorized to transact insurance if it has and maintains surplus funds as follows:

(a) to transact property insurance, surplus funds of not less than $500,000;

(b) to transact casualty insurance:

(i) including authority for workers' compensation insurance, surplus funds of not less than $750,000; or

(ii) excluding authority for workers' compensation insurance, surplus funds of not less than $500,000.

(2) In addition to surplus funds required to be maintained under subsection (1), the insurer must have, when first authorized, expendable surplus in the same amount as required of a like foreign reciprocal insurer under 33-2-110.

(3) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the provisions of this code for the additional kinds of insurance and maintains surplus funds in an amount equal to the minimum capital stock required of a stock insurer for authority to transact a like combination of kinds of insurance.

History: En. Sec. 544, Ch. 286, L. 1959; R.C.M. 1947, 40-5007; amd. Sec. 1, Ch. 307, L. 1979; amd. Sec. 37, Ch. 379, L. 1995; amd. Sec. 34, Ch. 227, L. 2001.

Cross-References

Casualty insurance — definition, 33-1-206.
Property insurance — definition, 33-1-210.

33-5-402. Contributions to insurer. The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms funds that it may require from time to time in its operations. Sums advanced may not be treated as a liability of the insurer. Except upon liquidation of the insurer, during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed the lesser of the insurer's realized earned surplus or 10% of the sums advanced as of the previous December 31. A withdrawal or repayment may not be made without the advance approval of the commissioner. This section does not apply to bank loans or to loans for which security is given.

History: **En. Sec. 552, Ch. 286, L. 1959; R.C.M. 1947, 40-5015; amd. Sec. 19, Ch. 531, L. 1997; amd. Sec. 23, Ch. 472, L. 1999.**

33-5-403. Financial condition — method of determining. In determining the financial condition of a reciprocal insurer the commissioner shall apply the following rules:

(1) The commissioner shall charge as liabilities the same reserves that are required of incorporated insurers issuing nonassessable policies on a reserve basis.

(2) The surplus deposits of subscribers must be allowed as assets, except that any premium deposits delinquent for 90 days must first be charged against the surplus deposit.

(3) The surplus deposits of subscribers may not be charged as a liability.

(4) All premium deposits that are delinquent for less than 90 days must be allowed as assets.

(5) An assessment levied upon subscribers and not collected may not be allowed as an asset.

(6) The contingent liability of subscribers may not be allowed as an asset.

(7) The computation of reserves must be based upon premium deposits other than membership fees and without any deduction for expenses and the compensation of the attorney.

History: **En. Sec. 553, Ch. 286, L. 1959; R.C.M. 1947, 40-5016; amd. Sec. 1159, Ch. 56, L. 2009.**

33-5-404. Subscribers' liability. (1) The liability of each subscriber, other than as to a nonassessable policy, for the obligations of the reciprocal insurer must be an individual, several, and proportionate liability, and not joint liability.

(2) Except as to a nonassessable policy, each subscriber must have a contingent assessment liability, in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while the subscriber's policy was in force. The contingent liability may be at the rate of not less than 1 or more than 10 times the premium or premium deposit stated in the policy, and the maximum aggregate contingent liability must be computed in the manner set forth in 33-5-406.

(3) Each assessable policy issued by the insurer must contain a statement of the contingent liability.

History: **En. Sec. 556, Ch. 286, L. 1959; R.C.M. 1947, 40-5019; amd. Sec. 1160, Ch. 56, L. 2009.**

33-5-405. Subscribers' liability on judgment. (1) An action may not lie against any subscriber upon any obligation claimed against the insurer until a final judgment has been obtained against the insurer and remains unsatisfied for 30 days.

(2) Any judgment described in subsection (1) is binding upon each subscriber only in the proportion that the subscriber's interests may appear and in an amount not exceeding the subscriber's contingent liability, if any.

History: **En. Sec. 557, Ch. 286, L. 1959; R.C.M. 1947, 40-5020; amd. Sec. 1161, Ch. 56, L. 2009.**

33-5-406. Assessments. (1) Assessments may from time to time be levied upon subscribers of a domestic reciprocal insurer liable for the assessment under the terms of their policies by the attorney upon approval in advance by the subscribers' advisory committee and the commissioner or by the commissioner in liquidation of the insurer.

(2) Each subscriber's share of a deficiency for which an assessment is made, but not exceeding in any event the subscriber's aggregate contingent liability as stated in accordance with 33-5-404, must be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment the ratio of the total deficiency to the total premiums earned during the period upon all policies subject to the assessment.

(3) In computing the earned premiums for the purposes of this section, the gross premium received by the insurer for the policy must be used as a base, deducting only charges not recurring upon the renewal or extension of the policy.

(4) A subscriber may not have an offset against any assessment for which the subscriber is liable on account of any claim for unearned premium or losses payable.

History: **En. Sec. 558, Ch. 286, L. 1959; R.C.M. 1947, 40-5021; amd. Sec. 1162, Ch. 56, L. 2009.**

33-5-407. Time limit for assessments. Every subscriber of a domestic reciprocal insurer having contingent liability must be liable for and shall pay the subscriber's share of any assessment, as computed and limited in accordance with this chapter, if:

(1) while the subscriber's policy is in force or within 1 year after its termination, the subscriber is notified by either the attorney or the commissioner of the intention to levy an assessment; or

(2) an order to show cause why a receiver, conservator, rehabilitator, or liquidator of the insurer should not be appointed is issued while the subscriber's policy is in force or within 1 year after its termination.

History: En. Sec. 559, Ch. 286, L. 1959; R.C.M. 1947, 40-5022; amd. Sec. 1163, Ch. 56, L. 2009.

Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.

33-5-408. Aggregate liability. No one policy or subscriber as to such policy shall be assessed or charged with an aggregate of contingent liability as to obligations incurred by a domestic reciprocal insurer in any one calendar year in excess of the amount provided for in the power of attorney or in the subscribers' agreement, computed solely upon premium earned on such policy during that year.

History: En. Sec. 560, Ch. 286, L. 1959; R.C.M. 1947, 40-5023.

33-5-409. Nonassessable policies. (1) If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock required of a domestic stock insurer authorized to transact similar kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee, the commissioner shall issue a certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this state and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this state for as long as all the surplus remains unimpaired.

(2) Upon impairment of the surplus, the commissioner shall revoke the certificate. The revocation may not make a policy subject to contingent liability if the policy is then in force and for the remainder of the period for which the premium has been paid. However, after the revocation, a policy may not be issued or renewed without providing for contingent assessment liability of the subscriber.

(3) The commissioner may not authorize a domestic reciprocal insurer to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued unless it qualifies to and does extinguish the liability of all its subscribers and in all policies for all kinds of insurance transacted by it. However, if required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of those of its subscribers that may acquire the policies in that state and need not extinguish the contingent liability applicable to policies previously in force in that state.

History: En. Sec. 561, Ch. 286, L. 1959; R.C.M. 1947, 40-5024; amd. Sec. 1164, Ch. 56, L. 2009.

Cross-References

Contested case administrative hearings, 2-4-102.

Hearings by Commissioner, 33-1-313.

33-5-410. Distribution of savings. A reciprocal insurer may from time to time return to its subscribers any unused premiums, savings, or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks or policies or between subscribers, but this shall not prevent retrospective rating, distribution on a retrospective plan, or distribution varying as to classes of subscribers based on the experience of such subscribers.

History: En. Sec. 562, Ch. 286, L. 1959; R.C.M. 1947, 40-5025.

33-5-411. Subscribers' share in assets. Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus made as provided in 33-5-402, and the return of any unused premium, savings, or credits then standing on subscribers' accounts shall be distributed to its subscribers who were such within the 12 months prior to the last termination of its certificate of authority, according to such reasonable formula as the commissioner may approve.

History: En. Sec. 563, Ch. 286, L. 1959; R.C.M. 1947, 40-5026.

33-5-412. Impaired reciprocals. (1) If the assets of a reciprocal insurer are at any time insufficient to discharge its liabilities, other than any liability on account of funds contributed by the attorney or others, and to maintain the required surplus, its attorney shall make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency, but subject to the limitation set forth in the power of attorney or policy.

(2) If the attorney fails to make up the deficiency or to make the assessment within 30 days after the commissioner orders the attorney to do so or if the deficiency is not fully made up within 60 days after the date the assessment was made, the insurer is considered insolvent and must be proceeded against as authorized by this code.

(3) If liquidation of an insurer is ordered, an assessment must be levied upon the subscriber for an amount, subject to limits as provided by this chapter, that the commissioner determines to be necessary to discharge all liabilities of the insurer, exclusive of any funds contributed by the attorney or other persons but including the reasonable cost of the liquidation.

History: En. Sec. 565, Ch. 286, L. 1959; R.C.M. 1947, 40-5028; amd. Sec. 1165, Ch. 56, L. 2009.

Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.

33-5-413. Annual statement. (1) The annual statement of a reciprocal insurer shall be made and filed by its attorney.

(2) The statement shall be supplemented by such information as may be required by the commissioner relative to the affairs and transactions of the attorney insofar as they relate to the reciprocal insurer.

History: En. Sec. 551, Ch. 286, L. 1959; R.C.M. 1947, 40-5014.

Part 5
Insurance Operations

33-5-501. Insuring powers of reciprocals. (1) A reciprocal insurer may, upon qualifying therefor as provided for by this code, transact any kind or kinds of insurance defined by this code, other than life or title insurances.

(2) Such an insurer may purchase reinsurance and may grant reinsurance as to any kind of insurance it is authorized to transact.

History: En. Sec. 541, Ch. 286, L. 1959; R.C.M. 1947, 40-5004.

Cross-References

Types of insurance — definitions, 33-1-205 through 33-1-212.

Reinsurance — general provisions, Title 33, ch. 2, part 12.

33-5-502. Certificate of authority. (1) The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

(2) The commissioner may refuse, suspend, or revoke the certificate of authority, in addition to other grounds therefor, for failure of the attorney to comply with any provision of this code.

History: En. Sec. 546, Ch. 286, L. 1959; R.C.M. 1947, 40-5009.

Cross-References

Revocation or suspension of certificate of authority — generally, 33-2-118, 33-2-119.

33-5-503. Eligible subscribers — liability of representative. (1) Individuals, partnerships, and corporations of this state may make application, enter into agreement for, hold policies or contracts in or with, and be a subscriber of any domestic, foreign, or alien reciprocal insurer. Any corporation now or hereafter organized under the laws of this state shall, in addition to the rights, powers, and franchises specified in its articles of incorporation, have full power and authority as a subscriber to exchange insurance contracts through such reciprocal insurer. The right to exchange such contracts is hereby declared to be incidental to the purposes for which such corporations are organized and to be as fully granted as the rights and powers expressly conferred upon such corporations.

(2) Government or governmental agencies, state or political subdivisions thereof, boards, associations, estates, trustees, or fiduciaries are authorized to exchange nonassessable reciprocal interinsurance contracts with each other and with individuals, partnerships, and corporations to the same extent that individuals, partnerships, and corporations are herein authorized to exchange reciprocal interinsurance contracts.

(3) Any officer, representative, trustee, receiver, or legal representative of any such subscriber shall be recognized as acting for or on its behalf for the purpose of such contract but shall not be personally liable upon such contract by reason of acting in such representative capacity.

History: En. Sec. 554, Ch. 286, L. 1959; R.C.M. 1947, 40-5017.

CHAPTER 6
BENEVOLENT ASSOCIATIONS

Part 1 — General Provisions

33-6-101. Repealed.
33-6-102. Definition.
33-6-103. New benevolent associations prohibited — foreign associations.
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Part 1
General Provisions

33-6-101. Repealed. Sec. 6, Ch. 26, L. 2019.

History: (1), (2)En. Sec. 521, Ch. 286, L. 1959; Sec. 40-4901, R.C.M. 1947; (3)En. Sec. 537, Ch. 286, L. 1959; amd. Sec. 1, Ch. 297, L. 1971; Sec. 40-4917, R.C.M. 1947; R.C.M. 1947, 40-4901, 40-4917; amd. Sec. 141, Ch. 575, L. 1981; amd. Sec. 45, Ch. 304, L. 1999; amd. Sec. 9, Ch. 60, L. 2019.

33-6-102. Definition. (1) An entity is considered a "benevolent association" for the purposes of this chapter if the entity:

(a) is a corporation, association, or society, or by whatever name called, that issues any certificate, policy, or membership agreement or makes any promise or agreement with its members under which, upon the death of a member, any money or other benefit, charity, aid, or relief is to be paid, provided, or rendered by the corporation, association, or society to the deceased's legal representatives or to the beneficiary designated by the deceased and the money, benefit, charity, aid, or relief is derived from voluntary donations or from admission fees, dues, or assessments or any of those items collected or to be collected from the members of the entity or members of a class of the entity or interest or gains on the items or accumulations of the items; and

(b) uses the money or other benefit, charity, aid, or relief for the uses and purposes specified in this chapter, the uses of the corporation, association, or society, or the expenses of management and prosecution of its business.

(2) The definition of benevolent association in subsection (1) is not applicable to:

(a) burial or death benefits, annuities, endowments, or any other benefit payments of any legal reserve life or disability insurer or of any labor union, railroad brotherhood, or lodge having as a primary business the improvement of working conditions;

(b) any auxiliaries to any labor union, railroad brotherhood, or lodge referred to in subsection (2)(a); or

(c) the benevolent plans within fraternal orders if limited to members and if the plan is not the principal object for the formation or continuance of the fraternal order.

History: (1)En. Sec. 522, Ch. 286, L. 1959; amd. Sec. 20, Ch. 535, L. 1975; Sec. 40-4902, R.C.M. 1947; (2) thru (4)En. Secs. 523, 524, 525, Ch. 286, L. 1959; Secs. 40-4903, 40-4904, 40-4905, R.C.M. 1947; R.C.M. 1947, 40-4902, 40-4903, 40-4904, 40-4905; amd. Sec. 1166, Ch. 56, L. 2009; amd. Sec. 1, Ch. 26, L. 2019.

33-6-103. New benevolent associations prohibited — foreign associations. (1) A benevolent association may not transact or be authorized to transact any business in this state if the benevolent association did not have authority to transact business in this state immediately prior to January 1, 1961.

(2) A new benevolent association may not be organized or formed in this state on or after January 1, 1961.

(3) A benevolent association formed or existing under the laws of any other state or jurisdiction may not be authorized to transact business in this state.

History: En. Sec. 526, Ch. 286, L. 1959; R.C.M. 1947, 40-4906; amd. Sec. 2, Ch. 26, L. 2019.

33-6-104. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 527, Ch. 286, L. 1959; R.C.M. 1947, 40-4907.

Part 2
Management
(Repealed)

33-6-201. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 528, Ch. 286, L. 1959; R.C.M. 1947, 40-4908.

Part 3
Finance
(Repealed)

33-6-301. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 531, Ch. 286, L. 1959; R.C.M. 1947, 40-4911.

33-6-302. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 533, Ch. 286, L. 1959; amd. Sec. 1, Ch. 224, L. 1975; R.C.M. 1947, 40-4913.

33-6-303. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 535, Ch. 286, L. 1959; R.C.M. 1947, 40-4915.

33-6-304. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 536, Ch. 286, L. 1959; R.C.M. 1947, 40-4916; amd. Sec. 2, Ch. 337, L. 1987.

Part 4
Insurance Operations
(Repealed)

33-6-401. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. 40-4918 by Sec. 2, Ch. 297, L. 1971; R.C.M. 1947, 40-4918(part); amd. Sec. 3, Ch. 327, L. 1987; amd. Sec. 1167, Ch. 56, L. 2009.

33-6-402. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 529, Ch. 286, L. 1959; R.C.M. 1947, 40-4909; amd. Sec. 146, Ch. 575, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-6-403. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 530, Ch. 286, L. 1959; R.C.M. 1947, 40-4910; amd. Sec. 1, Ch. 713, L. 1989.

33-6-404. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 532, Ch. 286, L. 1959; R.C.M. 1947, 40-4912.

33-6-405. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 534, Ch. 286, L. 1959; R.C.M. 1947, 40-4914.

CHAPTER 7
FRATERNAL BENEFIT SOCIETIES

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33-7-105. Fraternal benefit societies.
33-7-106. Lodge system.
33-7-107. Representative form of government.
33-7-108. Definitions.

33-7-109. Purposes and powers.
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33-7-120. Injunction — liquidation — receivership of domestic society.
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33-7-531. Foreign or alien society — admission.
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Part 1
General Provisions

33-7-101. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Secs. 617, 672, Ch. 286, L. 1959; R.C.M. 1947, 40-5304, 40-5359; amd. Sec. 141, Ch. 575, L. 1981; amd. Sec. 2, Ch. 139, L. 1987; amd. Sec. 15, Ch. 713, L. 1989.

33-7-102. Repealed. Sec. 41, Ch. 586, L. 1991.

History: (1), (2)En. Sec. 614, Ch. 286, L. 1959; Sec. 40-5301, R.C.M. 1947; (3)En. Sec. 615, Ch. 286, L. 1959; Sec. 40-5302, R.C.M. 1947; (4)En. Sec. 616, Ch. 286, L. 1959; Sec. 40-5303, R.C.M. 1947; R.C.M. 1947, 40-5301, 40-5302, 40-5303.

33-7-103. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 645, Ch. 286, L. 1959; R.C.M. 1947, 40-5332.

33-7-104. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 618, Ch. 286, L. 1959; amd. Sec. 21, Ch. 535, L. 1975; R.C.M. 1947, 40-5305.

33-7-105. Fraternal benefit societies. Any incorporated or unincorporated society, order, or supreme lodge, without capital stock, including a society exempted under the provisions of 33-7-126(1)(b), that is conducted solely for the benefit of its members and their beneficiaries and not for profit, that is operated on a lodge system with ritualistic forms of work, that has a representative form of government, and that provides benefits in accordance with this chapter, is a fraternal benefit society.

History: En. Sec. 1, Ch. 586, L. 1991.

33-7-106. Lodge system. (1) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated, or admitted in accordance with its laws, rules, and ritual. Subordinate lodges must be required by the laws of the society to hold regular meetings at least once a month in furtherance of the purposes of the society.

(2) A society may organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges may not be required of children, and children may not have a voice or vote in the management of a society.

History: En. Sec. 2, Ch. 586, L. 1991.

33-7-107. Representative form of government. (1) A society has a representative form of government if it has a supreme governing body organized as provided in subsection (2) or (3).

(2) (a) The supreme governing body may be an assembly composed of delegates who meet the criteria of subsection (5) and who are elected either by the members directly or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail.

(b) The delegates elected must be a majority of delegates and may not have less than a majority of the votes and not less than the number of votes required to amend the society's laws. The assembly must be elected and shall meet at least once every 4 years and shall elect a board of directors to conduct the business of the society between meetings of the assembly.

(c) Vacancies on the board of directors may be filled in the manner prescribed by the society's laws.

(3) (a) (i) The supreme governing body may be:

(A) a board composed of persons who meet the criteria of subsection (5) and who are elected by the members, either directly or by their representatives in intermediate assemblies; and

(B) any other persons prescribed in the society's laws.

(ii) A society may provide for election of the board by mail.

(b) The term of a board member may not exceed 4 years. Vacancies on the board may be filled in the manner prescribed in the society's laws.

(c) The persons elected to the board must be a majority of the board and may not be less than the number of votes required to amend the society's laws. A person filling an unexpired term of an elected board member is considered to be an elected board member.

(d) The board shall meet at least quarterly to conduct the business of the society.

(4) The officers of the society must be elected either by the assembly or by the board of directors, either of which constitutes the supreme governing body.

(5) Only benefit members are eligible for election to the assembly, the board of directors, or an intermediate assembly.

(6) Each voting member shall have one vote. A vote may not be cast by proxy.

History: En. Sec. 3, Ch. 586, L. 1991.

33-7-108. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Benefit contract" means the agreement for provision of authorized benefits described in 33-7-520.

(2) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(3) "Certificate" means the document issued as written evidence of the benefit contract.

(4) "Laws" means the society's articles of incorporation, charter, constitution, and bylaws.

(5) "Lodge" means subordinate member units of the society, known as camps, courts, councils, or branches or by any other designation.

(6) "Premiums" means premiums, rates, dues, or other required contributions that are payable under the certificate.

(7) "Rules" means all rules, regulations, or resolutions that are adopted by the supreme governing body or board of directors and that are intended to have general application to the members of the society.

(8) "Society" means a fraternal benefit society described in 33-7-105. The term includes an order or supreme lodge.

History: En. Sec. 4, Ch. 586, L. 1991.

33-7-109. Purposes and powers. (1) A society shall operate for the benefit of members and their beneficiaries by:

(a) providing benefits as provided in 33-7-520; and

(b) providing for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic, or religious purposes, which may be extended to others. The purposes may be carried out directly by the society or indirectly through subsidiary corporations or affiliated organizations.

(2) A society may adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It may amend laws and rules and exercise powers necessary and incidental to the objectives and purposes of the society.

History: En. Sec. 5, Ch. 586, L. 1991.

33-7-110. Qualification for membership. (1) A society shall specify in its laws or rules:

(a) eligibility standards for each class of membership. However, if benefits are provided on the lives of children, the minimum age for adult membership must be set at not less than 15 years of age and not more than 21 years of age.

(b) the process for admission to each membership class; and

(c) the rights and privileges of each membership class. However, only benefit members may vote on the management of the insurance affairs of the society.

(2) A society may admit social members who have no voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in the society are personal to the member and are not assignable.

History: En. Sec. 6, Ch. 586, L. 1991.

33-7-111. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 653, Ch. 286, L. 1959; R.C.M. 1947, 40-5340; amd. Sec. 1, Ch. 713, L. 1989.

33-7-112. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 654, Ch. 286, L. 1959; R.C.M. 1947, 40-5341.

33-7-113. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 655, Ch. 286, L. 1959; R.C.M. 1947, 40-5342.

33-7-114. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 665, Ch. 286, L. 1959; R.C.M. 1947, 40-5352.

33-7-115. Repealed. Sec. 41, Ch. 586, L. 1991.

History: Ap. p. Sec. 669, Ch. 286, L. 1959; Sec. 40-5356, R.C.M. 1947; Ap. p. Sec. 670, Ch. 286, L. 1959; Sec. 40-5357, R.C.M. 1947; R.C.M. 1947, 40-5356, 40-5357.

33-7-116. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 671, Ch. 286, L. 1959; R.C.M. 1947, 40-5358.

33-7-117. Scope — provisions applicable. (1) Except as provided in subsection (2), societies are governed by this chapter and are exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. The provisions of a law enacted after January 1, 1992, do not apply to fraternal benefit societies unless expressly made applicable by the provisions of the law.

(2) In addition to the provisions of this chapter, the provisions of chapter 1, parts 1 through 4 and 7; 33-2-104; 33-2-107; 33-2-112; chapter 2, parts 13 and 19; 33-3-308; 33-3-701 through 33-3-704; 33-15-502; and chapters 17, 18, 20, and 22 apply to fraternal benefit societies to the extent applicable and to the extent not in conflict with the provisions of this chapter and the reasonable implications of this chapter.

History: En. Sec. 23, Ch. 586, L. 1991; amd. Sec. 38, Ch. 379, L. 1995; amd. Sec. 12, Ch. 63, L. 2015.

33-7-118. Reports — fee. Reports must be filed in accordance with the provisions of this section.

(1) On or before March 1 of each year, unless for cause shown the time has been extended by the commissioner of insurance, a society that transacts business in this state shall file with the commissioner of insurance a statement of its financial condition, transactions, and affairs for the preceding calendar year and pay a filing fee of $25. The statement must be in the general form and context approved by the national association of insurance commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(2) As part of the annual statement, each society shall, on or before March 1, file with the commissioner a valuation of its certificates in force on the preceding December 31. The commissioner may, for cause shown, extend for not more than 2 calendar months the time for filing the valuation. The valuation must be done in accordance with the standards specified in 33-7-411. The valuation and underlying data must be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(3) A society that fails to file the annual statement in the form and within the time provided by this section shall forfeit $100 for each day during which the failure continues, and, upon notice by the commissioner to that effect, its authority to do business in this state ceases while the default continues.

History: **En. Sec. 26, Ch. 586, L. 1991.**

33-7-119. Examination of societies. (1) The commissioner of insurance or any person appointed by the commissioner may examine any domestic, foreign, or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign, or alien insurers. Requirements of notice and an opportunity to respond before findings are made public, as provided in the laws regulating insurers, are applicable to the examination of societies.

(2) The expense of each examination and of each valuation, including compensation and actual expenses of examiners, must be paid by the society examined or whose certificates are valued, upon statements furnished by the commissioner.

History: **En. Sec. 28, Ch. 586, L. 1991; amd. Sec. 1168, Ch. 56, L. 2009.**

33-7-120. Injunction — liquidation — receivership of domestic society. (1) The commissioner of insurance shall notify a domestic society of a deficiency or deficiencies and state in writing the reasons for the dissatisfaction, whenever the commissioner, upon investigation, finds that the society:

(a) has exceeded its powers;

(b) has failed to comply with any provision of this chapter;

(c) is not fulfilling its contracts in good faith;

(d) has a membership of less than 400 after an existence of 1 year or more; or

(e) is conducting business fraudulently or in a manner hazardous to its members, creditors, the public, or the business.

(2) Whenever a deficiency or deficiencies are found, the commissioner shall issue to the society a written notice that requires the deficiency or deficiencies to be corrected. The society shall within 30 days comply with the commissioner's request for correction. If the society fails to comply, the commissioner shall notify the society of the noncompliance and require the society to show cause by a stated date why it should not be enjoined from transacting business until the violation complained of is corrected or why an action in quo warranto should not be commenced against the society.

(3) If the society does not present sufficient reasons why it should not be enjoined from transacting business or why the quo warranto action should not be commenced, the commissioner may present the facts relating to the commissioner's determination to the attorney general who shall, if the attorney general finds that the circumstances warrant, commence an action to enjoin the society from transacting business or an action in quo warranto.

(4) The court shall notify the officers of the society of a hearing. If after a hearing it appears that the society should be enjoined or liquidated or that a receiver should be appointed, the court shall enter the necessary order. A society enjoined from transacting business may not do business until:

(a) the commissioner finds that the violation complained of has been corrected;

(b) the costs of the action have been paid by the society if the court finds that the society was in default as charged;

(c) the court has dissolved its injunction; and

(d) the commissioner has reinstated the certificate of authority.

(5) If the court orders the society liquidated, it is enjoined from transacting any further business. The receiver of the society shall proceed at once to take possession of the books, papers, money, and other assets of the society and, under the direction of the court, proceed to close the affairs of the society and distribute its funds to those entitled to the funds.

(6) An action under this section may not be recognized in any court of this state unless brought by the attorney general upon request of the commissioner. The court shall appoint the commissioner as the receiver for a domestic society.

(7) The provisions of this section relating to hearing by the commissioner, action by the attorney general at the request of the commissioner, hearing by the court, injunction, and receivership apply to a society that voluntarily decides to discontinue business.

History: **En. Sec. 30, Ch. 586, L. 1991; amd. Sec. 1169, Ch. 56, L. 2009.**

33-7-121. Suspension, revocation, or refusal of license of foreign or alien society. (1) The commissioner of insurance shall notify a foreign or alien society of a deficiency or deficiencies and state in writing the reasons for the commissioner's dissatisfaction whenever the commissioner, upon investigation, finds that the society transacting or applying to transact business in this state:

(a) has exceeded its powers;

(b) has failed to comply with any of the provisions of this chapter;

(c) is not fulfilling its contracts in good faith; or

(d) is conducting its business fraudulently or in a manner hazardous to its members, creditors, or the public.

(2) Whenever a deficiency or deficiencies are found, the commissioner shall issue to the society a written notice that requires the deficiency or deficiencies to be corrected. The society shall within 30 days comply with the commissioner's request for correction. If the society fails to comply, the commissioner shall notify the society of the noncompliance and require the society to show cause by a stated date why its authority to do business in this state should not be suspended, revoked, or refused.

(3) If the society does not present sufficient reason why its authority to do business in this state should not be suspended, revoked, or refused, the commissioner may:

(a) suspend or refuse the authority of the society to do business in this state until satisfactory evidence is furnished to the commissioner that the suspension or refusal should be withdrawn; or

(b) revoke the authority of the society to do business in this state.

(4) This section may not be construed as preventing any society from continuing in good faith all contracts made in this state during the time the society was legally authorized to transact business in this state.

History: **En. Sec. 31, Ch. 586, L. 1991; amd. Sec. 1170, Ch. 56, L. 2009.**

33-7-122. Injunction. An application or petition for injunction against any domestic, foreign, or alien society or lodge of a society may not be recognized in any court of this state unless made by the attorney general upon request of the commissioner of insurance.

History: **En. Sec. 32, Ch. 586, L. 1991.**

Cross-References

Injunctions, Title 27, ch. 19.

33-7-123. Repealed. Sec. 54, Ch. 157, L. 2023.

History: **En. Sec. 35, Ch. 586, L. 1991.**

33-7-124. Review. All decisions and findings of the commissioner of insurance made under the provisions of this chapter are subject to review by the court in accordance with the provisions of 33-1-711.

History: **En. Sec. 36, Ch. 586, L. 1991.**

33-7-125. Penalties. (1) A person who makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from a benefit in any society is guilty of a misdemeanor.

(2) A person who solicits membership for, or in any manner assists in procuring membership in, any society not authorized to transact business in this state is subject to an administrative fine, imposed by the commissioner of insurance, of not less than $25 or more than $500 for each violation.

(3) A person convicted of a willful violation of, or neglect or refusal to comply with, any provision of this chapter for which a penalty is not otherwise prescribed shall be punished by a fine of not more than $1,000 for each violation and not more than $10,000 for all related violations.

History: **En. Sec. 37, Ch. 586, L. 1991.**

33-7-126. Exemption of certain societies. (1) Nothing in this chapter may be construed to affect or apply to:

(a) grand or subordinate lodges of societies, orders, or associations doing business in this state on July 1, 1992, that provide benefits exclusively through local or subordinate lodges;

(b) (i) orders, societies, or associations that admit to membership only persons engaged in one or more crafts or hazardous occupations or in the same or similar lines of business and that insure only their own members and their families; and

(ii) the ladies' societies or ladies' auxiliaries to such orders, societies, or associations;

(c) domestic societies that limit their membership to employees of a particular city or town, designated firm, business house, or corporation and that provide for a death benefit of not more than $400 or disability benefits of not more than $350 to any person in any 1 year, or both; or

(d) domestic societies or associations of a purely religious, charitable, or benevolent description, which provide for a death benefit of not more than $400 or for disability benefits of not more than $350 to a person in any 1 year, or both.

(2) A society or association described in subsection (1)(c) or (1)(d) that provides for death or disability benefits for which benefit certificates are issued and a society or association included in subsection (1)(d) that has more than 1,000 members are not exempt from the provisions of this chapter.

(3) A society that is exempt under this section from the requirements of this chapter, except a society described in subsection (1)(b), may not give or allow or promise to give or allow to any person any compensation for procuring new members.

(4) A society that provides for benefits in case of death or disability resulting solely from accident and that does not obligate itself to pay natural death or sick benefits has all of the privileges and is subject to all the applicable provisions and regulations of this chapter except the provisions of this chapter that relate to medical examination, valuations of benefit certificates, and incontestability.

(5) The commissioner may require from a society or association, by examination or otherwise, any information that will enable the commissioner to determine whether the society or association is exempt from the provisions of this chapter.

(6) A society that is exempt under the provisions of this section is also exempt from all other provisions of the insurance laws of this state.

History: **En. Sec. 38, Ch. 586, L. 1991.**

33-7-127. Service of process. Service of process against a society authorized to do business in this state must be made pursuant to 35-7-113 or in any other manner permitted by law.

History: **En. Sec. 13, Ch. 157, L. 2023.**

Part 2
Formation

33-7-201. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 622, Ch. 286, L. 1959; R.C.M. 1947, 40-5309.**

33-7-202. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 623, Ch. 286, L. 1959; R.C.M. 1947, 40-5310.**

33-7-203. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 624, Ch. 286, L. 1959; R.C.M. 1947, 40-5311.**

33-7-204. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 625, Ch. 286, L. 1959; R.C.M. 1947, 40-5312.**

33-7-205. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 626, Ch. 286, L. 1959; R.C.M. 1947, 40-5313.**

33-7-206. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 629, Ch. 286, L. 1959; R.C.M. 1947, 40-5316(part).**

33-7-207. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 628, Ch. 286, L. 1959; R.C.M. 1947, 40-5315.**

33-7-208. Organization. A domestic society organized on or after January 1, 1992, must be formed as follows:

(1) Ten or more citizens of the United States, a majority of whom are residents of this state, who desire to form a fraternal benefit society, may make, sign, and acknowledge before a notary public an application for articles of incorporation that states:

(a) the proposed corporate name of the society, which may not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(b) the purposes for which it is being formed and the mode in which its corporate powers are to be exercised. The purposes may not include more liberal powers than are granted by this chapter.

(c) the names and residences of the incorporators and the names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all officers are elected by the supreme governing body. The election must be held not later than 1 year from the date of issuance of the permanent certificate of authority.

(2) The application for articles of incorporation, certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications for certificates, and circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within 1 year must be filed with the commissioner, who may require further information considered necessary. The bond, with sureties approved by the commissioner, must be in an amount, not less than $300,000 or more than $1,500,000, required by the commissioner. All documents filed must be in English. If the purposes of the society conform to the requirements of this chapter and all provisions of law have been complied with, the commissioner shall certify, retain, and file the articles of incorporation and furnish to the incorporators a preliminary certificate of authority authorizing the society to solicit members.

(3) A preliminary certificate of authority granted under the provisions of this section is not valid after 1 year from its date of issuance or after an extended period, not exceeding 1 year, as may be authorized by the commissioner upon good cause shown, unless the 500 applicants required under subsection (4) have been secured and the organization has been completed. The charter and all other proceedings under the charter are void 1 year from the date of issuance of the preliminary certificate of authority or at the expiration of the extended period unless the society has completed its organization and received a certificate of authority to do business.

(4) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each applicant a receipt for the amount collected. A society may not incur a liability other than for the return of an advance premium, issue any certificate, or pay, allow, offer, or promise to pay or allow any benefit to a person until:

(a) actual applications for benefits have been secured, aggregating at least $500,000, on not less than 500 applicants and any necessary evidence of insurability has been furnished to and approved by the society;

(b) at least 10 subordinate lodges have been established into which the 500 applicants have been admitted;

(c) there has been submitted to the commissioner, under oath of the president, secretary, or corresponding officer of the society, a list of the applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted, and premiums for benefits; and

(d) it has been shown to the commissioner, by sworn statement of the treasurer or the corresponding officer of the society, that at least 500 applicants have each paid in cash at least one regular monthly premium. The aggregate premiums must amount to at least $150,000. The advance premiums must be held in trust during the period of organization. If the society has not qualified for a certificate of authority within 1 year, unless extended as provided in subsection (3), the premiums must be returned to the applicants.

(5) The commissioner may require and examine additional information that the commissioner considers advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue a certificate of authority to the society, authorizing it to transact business pursuant to the provisions of this chapter. The certificate of authority is prima facie evidence of the existence of the society at the date of the certificate. The commissioner shall record the certificate of authority.

(6) A society authorized to transact business in this state on January 1, 1992, is not required to reincorporate.

(7) An unincorporated or voluntary association may not transact business in this state as a society. Every voluntary association incorporated as provided in section 629(2), Chapter 286, Laws of 1959, may incur the obligations and enjoy the benefits of a society as if it were originally incorporated, and the corporation is considered a continuation of the original voluntary association. The officers must be elected and serve as provided in its articles of incorporation. Incorporation of a voluntary association does not affect existing suits, claims, or contracts.

History: En. Sec. 10, Ch. 586, L. 1991; amd. Sec. 1171, Ch. 56, L. 2009.

33-7-209. Amendments to laws. (1) A domestic society may amend its laws in accordance with the provisions of its laws by action of its supreme governing body at any regular or special meeting or, if its laws provide, by referendum. The referendum may be held in accordance with the provisions of its laws by a vote of the voting members of the society, by a vote of delegates or representatives of voting members, or by a vote of local lodges. A society may provide for voting by mail. An amendment submitted by referendum may not be adopted unless, within 6 months from the date of submission, a majority of the members voting have signified their consent to the amendment.

(2) An amendment to the laws of a domestic society does not take effect unless approved by the commissioner of insurance, who shall approve the amendment if the commissioner finds that it has been adopted and is not inconsistent with any requirement of the laws of this state or with the character, objectives, and purposes of the society. Unless the commissioner disapproves an amendment within 60 days after its filing, the amendment is considered approved. The approval or disapproval of the commissioner must be in writing and mailed to the secretary or corresponding officer of the society at its principal office. If the commissioner disapproves an amendment, the reasons for the disapproval must be stated in the written notice.

(3) Within 90 days of approval by the commissioner, all amendments or a synopsis of the amendments must be furnished to all members of the society, either by mail or by publication in full in the official publication of the society.

(4) A foreign or alien society authorized to do business in this state shall file with the commissioner a certified copy of all amendments of or additions to its laws within 90 days after their enactment.

(5) Printed copies of the laws, as amended, that are certified by the secretary or a corresponding officer of the society are prima facie evidence of their legal adoption.

History: En. Sec. 11, Ch. 586, L. 1991; amd. Sec. 1172, Ch. 56, L. 2009.

33-7-210. Institutions. (1) A society may create, maintain, and operate, or may establish organizations to operate, not-for-profit institutions to further the purposes permitted by 33-7-109(1)(b). The institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held, or leased by the society for these purposes must be reported in every annual statement but may not be allowed as an admitted asset of the society.

(2) A society may not own or operate funeral homes or undertaking establishments.

History: En. Sec. 12, Ch. 586, L. 1991.

33-7-211. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 666, Ch. 286, L. 1959; R.C.M. 1947, 40-5353.

33-7-212. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 667, Ch. 286, L. 1959; R.C.M. 1947, 40-5354.

33-7-213. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 668, Ch. 286, L. 1959; R.C.M. 1947, 40-5355.

33-7-214. Reinsurance. (1) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make the reinsurance and authorized to do business in this state or, if not authorized to do business in this state, an insurer that is approved by the commissioner of insurance. A society may not reinsure substantially all of its insurance in force without the written permission of the commissioner. A society may take credit for the reserves on the ceded risks to the extent reinsured. A credit may not be allowed as an admitted asset or as a deduction from liability to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective on or after July 1, 1992, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(2) Notwithstanding the limitation in subsection (1), a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under 33-7-215.

History: **En. Sec. 13, Ch. 586, L. 1991.**

33-7-215. Consolidations and mergers. (1) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. The consolidated or merged society shall file with the commissioner of insurance:

(a) a certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(b) a sworn statement by the president and secretary or corresponding officers of each society showing the financial condition of each society on a date fixed by the commissioner, but not earlier than December 31 preceding the date of the contract;

(c) a certificate of the officers of each society, verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, held at a regular or special meeting of each body or, if the society's laws permit, by mail; and

(d) evidence that at least 60 days prior to the action of the supreme governing body of each society, the text of the contract was furnished to all members of each society, either by mail or by publication in full in the official publication of each society.

(2) If the commissioner finds that the contract containing the terms and conditions of the proposed consolidation or merger is in conformity with this section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate approving the contract.

(3) Upon approval, the contract is in full force and effect unless a society that is a party to the contract is incorporated under the laws of any other state, district, territory, province, or country. In that event, the consolidation or merger is not effective until it is approved as provided by the laws of that state, district, territory, province, or country and a certificate of approval has been filed with the commissioner of insurance of this state.

(4) When the consolidation or merger becomes effective, all the rights, franchises, and interests of the consolidated or merged societies in and to every type of property, real, personal, or mixed, and things in action pertaining to the property are vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by deeds. The title to any real property or interest in real property vested under the laws of this state in any of the societies consolidated or merged may not revert or be impaired by reason of the consolidation or merger, but the title vests in the society resulting from or remaining after the consolidation or merger.

(5) The affidavit of any officer of the society or of anyone authorized by the society to mail a notice or document, stating that the notice or document has been addressed and mailed, is prima facie evidence that the notice or document has been furnished to the addressees.

History: **En. Sec. 14, Ch. 586, L. 1991.**

33-7-216. Conversion of society into mutual life insurance company. A domestic society may be converted and licensed as a mutual life insurance company by compliance with all the applicable requirements of Title 33 if the plan of conversion has been approved by the commissioner of insurance. The board of directors shall prepare a written plan of conversion that sets forth in full the terms and conditions of conversion. An affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting is necessary for the approval of the plan. A conversion may not take effect unless approved by the commissioner, who may approve the conversion if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

History: **En. Sec. 15, Ch. 586, L. 1991; amd. Sec. 1173, Ch. 56, L. 2009.**

33-7-217. Annual certificate — fees. (1) A society may not insure a risk in this state unless it holds a certificate of authority issued to it by the commissioner of insurance.

(2) A society's certificate of authority continues in force as long as the society is entitled to it under this chapter and until suspended, revoked, or otherwise terminated. However, continuance of the certificate by the society is conditioned upon payment before May 15 of each year of a continuation fee of $10. The fee must be deposited by the commissioner of insurance with the state treasurer to the credit of the state general fund.

(3) If a society does not continue its certificate of authority in accordance with subsection (2), its certificate of authority expires at midnight on the May 31 following its failure to continue it in force. In that case, the commissioner shall promptly notify the society of the impending expiration of its certificate of authority.

(4) The commissioner may reinstate a certificate of authority that a society has inadvertently permitted to expire, after the society has fully cured all failures that resulted in the expiration and upon payment by the society of a $25 fee for reinstatement in addition to the continuation fee provided for in subsection (2). If a certificate is not reinstated, the commissioner may grant a society another certificate of authority only after the society files an application for a certificate of authority and meets all other requirements for an original certificate of authority in this state.

(5) The commissioner may amend a certificate of authority at any time to conform to changes in a society's charter of insuring powers.

(6) A certified copy or duplicate of a certificate of authority is prima facie evidence that the society is a fraternal benefit society within the meaning of this chapter.

History: **En. Sec. 27, Ch. 586, L. 1991.**

Part 3
Management

33-7-301. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 627, Ch. 286, L. 1959; R.C.M. 1947, 40-5314.**

33-7-302. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 630, Ch. 286, L. 1959; R.C.M. 1947, 40-5317.**

33-7-303. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 631, Ch. 286, L. 1959; R.C.M. 1947, 40-5318.**

33-7-304. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 632, Ch. 286, L. 1959; R.C.M. 1947, 40-5319.**

33-7-305. Repealed. Sec. 41, Ch. 586, L. 1991.

History: **En. Sec. 633, Ch. 286, L. 1959; R.C.M. 1947, 40-5320.**

33-7-306. Location of office — meetings — communication to members — grievance procedures. (1) The principal office of a domestic society must be located in this state. The meetings of its supreme governing body may be held in any state, district, province, or territory where the society has at least five subordinate lodges or in a location determined by the supreme governing body. All business transacted at meetings is valid. The minutes of the proceedings of the supreme governing body and of the board of directors must be in English.

(2) (a) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Required reports, notices, and statements must be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is considered to be mailed to all members at the same address unless a member requests a separate copy.

(b) Not later than June 1 of each year, a synopsis of the society's annual statement, providing an explanation of the facts concerning the condition of the society, must be printed and mailed to each benefit member of the society, or the synopsis may be published in the society's official publication.

(3) A society may provide in its laws or rules for grievance or complaint procedures for members.

History: En. Sec. 7, Ch. 586, L. 1991.

Cross-References

Registered name and registered agent, 35-2-309.

33-7-307. No personal liability. (1) The officers and members of the supreme governing body or any subordinate body of a society are not personally liable for any benefits provided by a society.

(2) A person may be indemnified and reimbursed by a society for expenses reasonably incurred by and liabilities imposed upon the person in connection with or arising out of an action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat of a proceeding in which the person may be involved by reason of the fact that the person is or was a director, officer, employee, or agent of the society or of a firm, corporation, or organization that the person served in any capacity at the request of the society.

(3) (a) A person may not be indemnified or reimbursed in relation to any matter in an action, suit, or proceeding:

(i) in which the person is finally found to be guilty of breach of a duty as a director, officer, employee, or agent of the society; or

(ii) that is the subject of a compromise settlement.

(b) A person may be indemnified or reimbursed if the person acted in good faith for a purpose that the person reasonably believed to be in, or not opposed to, the best interests of the society and, in a criminal action or proceeding, in addition, did not have reasonable cause to believe that the conduct was unlawful.

(4) The determination of whether the person's conduct met the standard required in order to justify indemnification or reimbursement in relation to any matter described in subsection (3) may be made only by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to the action, suit, or proceeding or by a court of competent jurisdiction. The termination of an action, suit, or proceeding by a judgment, order, settlement, or conviction or upon a plea of no contest, does not create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification or reimbursement. The right of indemnification or reimbursement is not exclusive of other rights to which the person may be entitled as a matter of law, and the right inures to the benefit of the person's heirs, executors, and administrators.

(5) A director, officer, employee, member, or volunteer of a society who serves without compensation may not be held liable for and a cause of action may not be brought for damages resulting from the exercise of judgment or discretion in connection with the person's duties or responsibilities for the society unless the act or omission involved willful or wanton misconduct.

(6) A society may purchase and maintain liability insurance for acts incurred in the course and scope of the position for a person who is or was a director, officer, employee, or agent of the society or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization.

History: En. Sec. 8, Ch. 586, L. 1991; amd. Sec. 1174, Ch. 56, L. 2009.

33-7-308. Waiver. The laws of the society may provide that a subordinate body or any of its subordinate officers or members may not waive any of the provisions of the laws of the society. The provision is binding on the society and every member and beneficiary of a member.

History: En. Sec. 9, Ch. 586, L. 1991.

Part 4
Finance

33-7-401. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 635, Ch. 286, L. 1959; R.C.M. 1947, 40-5322.

33-7-402. Repealed. Sec. 41, Ch. 586, L. 1991.
History: **En. Sec. 648, Ch. 286, L. 1959; R.C.M. 1947, 40-5335.**

33-7-403. Repealed. Sec. 41, Ch. 586, L. 1991.
History: **En. Sec. 649, Ch. 286, L. 1959; R.C.M. 1947, 40-5336.**

33-7-404. Repealed. Sec. 41, Ch. 586, L. 1991.
History: **En. Sec. 650, Ch. 286, L. 1959; R.C.M. 1947, 40-5337.**

33-7-405. Repealed. Sec. 41, Ch. 586, L. 1991.
History: **En. Sec. 651, Ch. 286, L. 1959; R.C.M. 1947, 40-5338; amd. Sec. 13, Ch. 303, L. 1981.**

33-7-406. Repealed. Sec. 41, Ch. 586, L. 1991.
History: **En. Sec. 652, Ch. 286, L. 1959; R.C.M. 1947, 40-5339.**

33-7-407. Repealed. Sec. 41, Ch. 586, L. 1991.
History: **En. Sec. 656, Ch. 286, L. 1959; R.C.M. 1947, 40-5343.**

33-7-408. Investments. A society may invest its funds only in investments authorized by the laws of this state for the investment of assets of life insurers. A foreign or alien society that is permitted or seeking to do business in this state and that invests its funds in accordance with the laws of the state, district, territory, province, or country where it is incorporated meets the requirements of this section for the investment of funds.
History: **En. Sec. 21, Ch. 586, L. 1991.**

33-7-409. Funds. (1) All assets must be held, invested, and disbursed for the use and benefit of the society, and a member or beneficiary may not have or acquire individual rights in assets or become entitled to any apportionment on the surrender of any part of the assets except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the laws of the society.

(3) Pursuant to a resolution of its supreme governing body, a society may establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing similar accounts and issuing similar contracts. To the extent the society considers it necessary in order to comply with any applicable federal or state laws or any rules issued under those laws, the society may adopt special procedures for administering a separate account and may, for persons having beneficial interests in a separate account, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account. A society may issue contracts on a variable basis to which the provisions of 33-7-523(2) and (4) do not apply.
History: **En. Sec. 22, Ch. 586, L. 1991.**

33-7-410. Taxation. A society organized or licensed under this chapter is a charitable and benevolent institution, and all of its funds are exempt from all state, county, district, municipal, and school taxes other than taxes on real estate and office equipment.
History: **En. Sec. 24, Ch. 586, L. 1991.**

Cross-References
Business equipment tax on business personal property, 15-6-122.

33-7-411. Valuation. (1) Standards of valuation for certificates issued prior to July 1, 1993, must be those provided by the laws applicable immediately prior to July 1, 1992.

(2) (a) The minimum standards of valuation for certificates issued on or after July 1, 1993, must be based on the following tables:

(i) for certificates of life insurance—the commissioner of insurance's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial mortality table, the commissioner's 1958 standard ordinary mortality table, the commissioner's 1980 standard ordinary mortality table, or any more recent table made applicable to life insurers;

(ii) for annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits—the tables authorized for use by life insurers in this state.

(b) All of the certificates must be valued under valuation methods and standards, including interest assumptions, that are in accordance with the laws of this state applicable to life insurers that issue policies containing similar benefits.

(3) The commissioner may accept other standards for valuation if the commissioner finds that the reserves produced by the valuation will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The commissioner may vary the standards of mortality applicable to all benefit contracts on substandard lives or other extrahazardous lives by a society authorized to do business in this state.

(4) A society, with the consent of the commissioner of insurance of the state of domicile of the society and under conditions, if any, that the commissioner may impose, may establish and maintain reserves on its certificates in excess of required reserves, but the contractual rights of a benefit member may not be affected by the excess reserves.

History: En. Sec. 25, Ch. 586, L. 1991; amd. Sec. 1175, Ch. 56, L. 2009.

Part 5
Insurance Operations

33-7-501. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 619, Ch. 286, L. 1959; R.C.M. 1947, 40-5306(part); amd. Sec. 4, Ch. 327, L. 1987.

33-7-502. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 620, Ch. 286, L. 1959; R.C.M. 1947, 40-5307.

33-7-503. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 621, Ch. 286, L. 1959; R.C.M. 1947, 40-5308.

33-7-504. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 634, Ch. 286, L. 1959; amd. Sec. 9, Ch. 423, L. 1971; R.C.M. 1947, 40-5321(part).

33-7-505. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 634, Ch. 286, L. 1959; amd. Sec. 9, Ch. 423, L. 1971; R.C.M. 1947, 40-5321(part).

33-7-506. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 636, Ch. 286, L. 1959; R.C.M. 1947, 40-5323.

33-7-507. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 637, Ch. 286, L. 1959; amd. Sec. 16, Ch. 94, L. 1973; R.C.M. 1947, 40-5324(1).

33-7-508. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 637, Ch. 286, L. 1959; amd. Sec. 16, Ch. 94, L. 1973; R.C.M. 1947, 40-5324(2).

33-7-509. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 638, Ch. 286, L. 1959; R.C.M. 1947, 40-5325; amd. Sec. 14, Ch. 303, L. 1981.

33-7-510. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 639, Ch. 286, L. 1959; R.C.M. 1947, 40-5326.

33-7-511. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 640, Ch. 286, L. 1959; R.C.M. 1947, 40-5327.

33-7-512. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 641, Ch. 286, L. 1959; R.C.M. 1947, 40-5328.

33-7-513. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 642, Ch. 286, L. 1959; R.C.M. 1947, 40-5329.

33-7-514. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 643, Ch. 286, L. 1959; R.C.M. 1947, 40-5330; amd. Sec. 16, Ch. 198, L. 1979.

33-7-515. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 644, Ch. 286, L. 1959; R.C.M. 1947, 40-5331.

33-7-516. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 646, Ch. 286, L. 1959; R.C.M. 1947, 40-5333.

33-7-517. Repealed. Sec. 41, Ch. 586, L. 1991.
History: En. Sec. 647, Ch. 286, L. 1959; R.C.M. 1947, 40-5334.

33-7-518. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 663, Ch. 286, L. 1959; R.C.M. 1947, 40-5350.

33-7-519. Repealed. Sec. 41, Ch. 586, L. 1991.

History: En. Sec. 664, Ch. 286, L. 1959; R.C.M. 1947, 40-5351; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 35, Ch. 798, L. 1991.

33-7-520. Benefits. (1) A society may provide the following contractual benefits in any form:

(a) death benefits;

(b) endowment benefits;

(c) annuity benefits;

(d) temporary or permanent disability benefits;

(e) hospital, medical, or nursing benefits;

(f) monument or tombstone benefits to the memory of deceased members; and

(g) other benefits authorized for life insurers that are not inconsistent with this chapter.

(2) A society shall specify in its rules those persons who may be issued or covered by the contractual benefits in subsection (1), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

History: En. Sec. 16, Ch. 586, L. 1991.

33-7-521. Beneficiaries. (1) The owner of a benefit contract may change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that a revocable beneficiary may not have or obtain a vested interest in the proceeds of a certificate until the certificate becomes due and payable under the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits of up to $500 under a certificate due to a person equitably entitled to payment for the burial of a member.

(3) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds are payable, the amount of the benefit, except to the extent that funeral benefits may be paid as provided in subsection (2), is payable to the estate of the deceased. If the owner of the certificate is a person other than the insured, the proceeds are payable to the owner.

History: En. Sec. 17, Ch. 586, L. 1991.

33-7-522. Benefits not attachable. Money or other benefits, charity, relief, or aid to be paid, provided, or rendered by a society is not liable to attachment, garnishment, or other process and may not be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member, a beneficiary, or any other person who may have a right to the benefit, either before or after payment by the society.

History: En. Sec. 18, Ch. 586, L. 1991.

33-7-523. Benefit contract. (1) A society authorized to do business in this state shall issue to the owner of a benefit contract a certificate specifying the amount of benefits provided. The certificate must state that the certificate, together with any attached riders or endorsements, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each, constitutes the benefit contract, as of the date of issuance, between the society and the owner. A copy of the application for insurance and declaration of insurability, if any, must be endorsed upon or attached to the certificate. All statements on the application must be representations and not warranties. Any waiver of this provision is void.

(2) Any changes, additions, or amendments to the laws of the society made or enacted after the issuance of the certificate bind the owner and the beneficiaries and control the benefit contract in all respects as if the changes, additions, or amendments were in force at the time of the application for insurance. However, a change, addition, or amendment does not destroy or diminish benefits that the society contracted to give the owner as of the date of issuance.

(3) A person upon whose life a benefit contract is issued before attaining the age of majority is bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its laws that if its reserves for one or more classes of certificates become impaired, its board of directors or corresponding body may require that the owner of a certificate pay to the society the amount of the owner's equitable proportion of the deficiency as ascertained by its board and that if the payment is not made either:

(a) it is an indebtedness against the certificate and draws interest not to exceed the rate specified for certificate loans under the certificates; or

(b) in lieu of or in combination with the provisions of subsection (4)(a), the owner of the certificate may accept a proportionate reduction in benefits under the certificate.

(5) The society may specify the manner of election and which alternative under subsection (4) is to be presumed if no election is made.

(6) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, must be received in evidence concerning the terms and conditions of the documents.

(7) A certificate may not be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner of insurance in the manner provided for policies issued by life and disability insurers in this state. Certificates issued prior to July 1, 1993, must conform to the requirements provided by the laws applicable immediately prior to July 1, 1992. A life, disability, or annuity certificate issued on or after July 1, 1993, must meet the standard contract provision requirements not inconsistent with this chapter for policies issued by life and disability insurers in this state, except that a society may provide in its certificates for a grace period of 1 month for payment of premiums. The certificate must contain a provision stating the amount of premiums payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate that, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for the expulsion or suspension of a member, the certificate must contain a provision that a member expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, has the privilege of maintaining the certificate in force by continuing payment of the required premium.

(8) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and it may provide in all other respects for the regulation, government, and control of the certificates and all rights, obligations, and liabilities incident to and connected with the transfer. Ownership rights prior to the transfer must be specified in the certificate.

(9) A society may specify the terms and conditions on which benefit contracts may be assigned.

History: En. Sec. 19, Ch. 586, L. 1991.

33-7-524. Nonforfeiture benefits, cash surrender values, certificate loans, and other options. (1) For certificates issued prior to July 1, 1993, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted must comply with the provisions of law applicable immediately prior to July 1, 1992.

(2) For certificates issued on or after July 1, 1993, for which reserves are computed on the commissioner of insurance's 1941 standard ordinary mortality table, the commissioner's 1941 standard industrial mortality table, the commissioner's 1958 standard ordinary mortality table, the commissioner's 1980 standard mortality table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan, or other option granted may not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing similar benefits based upon the tables.

History: En. Sec. 20, Ch. 586, L. 1991.

33-7-525. Insurance producer defined — fraternal benefit society insurance contracts. (1) The term "insurance producer", as used in this chapter, means any authorized or acknowledged insurance producer of a society who acts as an insurance producer in the solicitation, negotiation, or sale of a life insurance, accident and health insurance, or annuity contract.

(2) The term does not include any regular salaried officer or employee of a licensed society who devotes substantially all of the officer's or employee's services to activities other than the solicitation of fraternal insurance contracts from the public and who receives for the solicitation of the contracts no commission or other compensation directly dependent upon the amount of business obtained.

History: En. Sec. 657, Ch. 286, L. 1959; R.C.M. 1947, 40-5344(2); amd. Sec. 15, Ch. 303, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 8, Ch. 427, L. 2003.

33-7-526. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Secs. 657, 658, Ch. 286, L. 1959; R.C.M. 1947, 40-5344(1), 40-5345; amd. Sec. 16, Ch. 303, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-7-527. Repealed. Sec. 29, Ch. 303, L. 1981.

History: En. Sec. 659, Ch. 286, L. 1959; R.C.M. 1947, 40-5346.

33-7-528. Repealed. Sec. 29, Ch. 303, L. 1981.

History: En. Sec. 660, Ch. 286, L. 1959; R.C.M. 1947, 40-5347.

33-7-529. Repealed. Sec. 29, Ch. 303, L. 1981.

History: En. Sec. 662, Ch. 286, L. 1959; R.C.M. 1947, 40-5349.

33-7-530. Repealed. Sec. 29, Ch. 303, L. 1981.

History: En. Sec. 661, Ch. 286, L. 1959; R.C.M. 1947, 40-5348.

33-7-531. Foreign or alien society — admission. (1) A foreign or alien society may not transact business in this state without a license issued by the commissioner of insurance. A foreign or alien society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. A society may be licensed to transact business in this state upon filing with the commissioner:

(a) a certified copy of its articles of incorporation;

(b) a copy of its bylaws, certified by its secretary or corresponding officer;

(c) a statement of its business, under oath of its president and secretary or corresponding officers, in a form prescribed by the commissioner, verified by an examination made by the supervising insurance official of its home state or other state, district, territory, province, or country satisfactory to the commissioner of this state;

(d) certification from the proper official of its home state, district, territory, province, or country that the society is legally incorporated and licensed to transact business in that jurisdiction;

(e) copies of its certificate forms; and

(f) other information the commissioner considers necessary.

(2) A foreign or alien society applying for authority to transact business in this state must have the qualifications required of domestic societies organized under this chapter.

History: En. Sec. 29, Ch. 586, L. 1991; amd. Sec. 14, Ch. 157, L. 2023.

33-7-532. Insurance producer licensing — fraternal benefit society. (1) A society's insurance producer is considered to be an insurance producer and is subject to the same licensing requirements as insurance producers under Title 33, chapter 17.

(2) A society doing business in this state may not pay to a person who is not a licensed insurance producer of the society any commission or other compensation for any services in obtaining in this state any new contract of life, accident, or health insurance or any new annuity contract.

History: En. Sec. 33, Ch. 586, L. 1991; amd. Sec. 9, Ch. 427, L. 2003.

33-7-533. Unfair methods of competition and unfair or deceptive acts and practices. A society authorized to do business in this state and its insurance producers are subject to the provisions of chapter 18 that relate to unfair or deceptive trade practices. However, nothing in chapter 18 may be construed as applying to or affecting the right of a society to determine its eligibility requirements for membership or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

History: En. Sec. 34, Ch. 586, L. 1991.

CHAPTER 8
INSURANCE ASSISTANCE PLANS
(Terminated)

Part 1 — Medical Liability (Terminated)

Part 2 — Montana Insurance Assistance Plan (Terminated)

Part 1
Medical Liability
(Terminated)

33-8-101. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6001 by Sec. 1, Ch. 246, L. 1977; R.C.M. 1947, 40-6001.

33-8-102. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6002 by Sec. 2, Ch. 246, L. 1977; R.C.M. 1947, 40-6002.

33-8-103. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6003 by Sec. 3, Ch. 246, L. 1977; R.C.M. 1947, 40-6003(1) thru (4).

33-8-104. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6003 by Sec. 3, Ch. 246, L. 1977; R.C.M. 1947, 40-6003(5).

33-8-105. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6003 by Sec. 3, Ch. 246, L. 1977; R.C.M. 1947, 40-6003(6).

33-8-106. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6004 by Sec. 4, Ch. 246, L. 1977; R.C.M. 1947, 40-6004(1).

33-8-107. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6004 by Sec. 4, Ch. 246, L. 1977; R.C.M. 1947, 40-6004(2)(a) thru (2)(e).

33-8-108. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6004 by Sec. 4, Ch. 246, L. 1977; R.C.M. 1947, 40-6004(2)(f).

33-8-109. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6005 by Sec. 5, Ch. 246, L. 1977; R.C.M. 1947, 40-6005.

33-8-110. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6006 by Sec. 6, Ch. 246, L. 1977; R.C.M. 1947, 40-6006.

33-8-111. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6007 by Sec. 7, Ch. 246, L. 1977; R.C.M. 1947, 40-6007.

33-8-112. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6008 by Sec. 8, Ch. 246, L. 1977; R.C.M. 1947, 40-6008.

33-8-113. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6009 by Sec. 9, Ch. 246, L. 1977; R.C.M. 1947, 40-6009.

33-8-114. Terminated. Sec. 1, Ch. 134, L. 1979.
History: En. 40-6010 by Sec. 10, Ch. 246, L. 1977; R.C.M. 1947, 40-6010.

33-8-115. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 1, Ch. 301, L. 1985.

33-8-116. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 2, Ch. 301, L. 1985.

33-8-117. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 3, Ch. 301, L. 1985.

33-8-118. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 4, Ch. 301, L. 1985.

33-8-119. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 5, Ch. 301, L. 1985.

33-8-120. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 6, Ch. 301, L. 1985.

33-8-121. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 7, Ch. 301, L. 1985.

33-8-122. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 8, Ch. 301, L. 1985.

33-8-123. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 9, Ch. 301, L. 1985.

33-8-124. Terminated. Sec. 1, Ch. 404, L. 1987.
History: En. Sec. 10, Ch. 301, L. 1985.

Part 2
Montana Insurance Assistance Plan (Terminated)

33-8-201. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 1, Ch. 11, Sp. L. March 1986.

33-8-202. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 2, Ch. 11, Sp. L. March 1986.

33-8-203. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 3, Ch. 11, Sp. L. March 1986.

33-8-204. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 15, Ch. 11, Sp. L. March 1986.

33-8-205. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 16, Ch. 11, Sp. L. March 1986.

33-8-206 through 33-8-210 reserved.

33-8-211. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 4, Ch. 11, Sp. L. March 1986.

33-8-212. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 5, Ch. 11, Sp. L. March 1986.

33-8-213. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 6, Ch. 11, Sp. L. March 1986; amd. Sec. 16, Ch. 713, L. 1989.

33-8-214. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 7, Ch. 11, Sp. L. March 1986.

33-8-215 through 33-8-220 reserved.

33-8-221. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 8, Ch. 11, Sp. L. March 1986.

33-8-222. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 9, Ch. 11, Sp. L. March 1986.

33-8-223 and 33-8-224 reserved.

33-8-225. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 10, Ch. 11, Sp. L. March 1986.

33-8-226. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 11, Ch. 11, Sp. L. March 1986.

33-8-227. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.
History: En. Sec. 12, Ch. 11, Sp. L. March 1986.

33-8-228. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.

History: En. Sec. 13, Ch. 11, Sp. L. March 1986.

33-8-229 and 33-8-230 reserved.

33-8-231. Terminated. Sec. 22, Ch. 11, Sp. L. March 1986.

History: En. Sec. 14, Ch. 11, Sp. L. March 1986.

CHAPTER 9
PROFESSIONAL LIABILITY INSURANCE

Part 1 — General Provisions

33-9-101. Definitions.
33-9-102. Professionals as members, stockholders, or subscribers of mutual, stock, or reciprocal insurers.
33-9-103. Incorporation and regulation.
33-9-104. Initial qualifications.
33-9-105. Foreign or alien insurers — certification.

Chapter Cross-References

Professional liability, Title 33, ch. 23, part 3.

Part 1
General Provisions

33-9-101. Definitions. As used in this part, the following definitions apply:

(1) "Health care provider" means any person, corporation, facility, or institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to physician, osteopath, registered nurse, licensed practical nurse, dentist, optometrist, podiatrist, hospital, hospital-related facility, or long-term care facility.

(2) "Other professional" means an attorney, certified public accountant, public accountant, architect, veterinarian, pharmacist, and professional engineer licensed or otherwise legally authorized by a state to render professional services.

History: En. 40-4759 by Sec. 1, Ch. 119, L. 1977; R.C.M. 1947, 40-4759(intro.), (2), (3).

33-9-102. Professionals as members, stockholders, or subscribers of mutual, stock, or reciprocal insurers. A health care provider or other professional may be a member of a mutual insurer, a stockholder of a stock insurer, or a subscriber of a reciprocal insurer, whether the mutual, stock, or reciprocal insurer is domestic, foreign, or alien, for the purpose of protecting the provider or professional by insurance against loss, damage, or expense incident to a claim arising out of a breach of contract, pecuniary or personal injury to or death of any person, or other loss as the result of negligence in rendering professional services by any health care provider or other professional.

History: En. 40-4760 by Sec. 2, Ch. 119, L. 1977; R.C.M. 1947, 40-4760; amd. Sec. 1176, Ch. 56, L. 2009.

33-9-103. Incorporation and regulation. A domestic mutual, stock, or reciprocal insurer, organized for the purpose of transacting insurance business as set forth in 33-9-102, shall organize under the provisions of Title 33 and be regulated as therein provided. The provisions of this part govern whenever in conflict with other laws or parts of laws of any state.

History: En. 40-4761 by Sec. 3, Ch. 119, L. 1977; R.C.M. 1947, 40-4761.

Cross-References

Formation of domestic mutual or stock insurers, Title 33, ch. 3, part 2.

Formation of reciprocal insurer, Title 33, ch. 5, part 2.

33-9-104. Initial qualifications. No original certificate of authority for a mutual, stock, or reciprocal insurer may be issued by the commissioner until applications representing 250 members of the profession under consideration have been received by the commissioner or in the case of health care providers that are hospitals, hospital-related facilities, or long-term care facilities, applications representing 50% of the beds in the state or states affected, and until the commissioner has determined that such insurer or insurers have bona fide applications representing the number of applicants required.

History: En. 40-4762 by Sec. 4, Ch. 119, L. 1977; R.C.M. 1947, 40-4762.

Cross-References

Original certificate of authority — general requirements, 33-2-115.

33-9-105. Foreign or alien insurers — certification. Any mutual, stock, or reciprocal insurer organized under the laws of another state substantially similar to this part for the purpose of transacting the kind of business described in this part may, upon an application and without prior operating experience or examination, be admitted to solicit applications. If the necessary number of applications is obtained, the insurer may do business in this state if the commissioner finds such admission is in the public interest. Thereafter the insurer shall make all reports and be subject to taxation, examination, and supervision by the commissioner to the same extent and in the same manner as are other foreign or alien insurers.

History: En. 40-4763 by Sec. 5, Ch. 119, L. 1977; R.C.M. 1947, 40-4763.

CHAPTER 10

INSURANCE GUARANTY ASSOCIATIONS

Part 1 — Casualty and Property Insurance Guaranty Associations

33-10-101. Short title, purpose, scope, and construction.
33-10-102. Definitions.
33-10-103. Creation of the association.
33-10-104. Board of directors — commissioner approval — compensation.
33-10-105. General powers and duties.
33-10-106. Plan of operation — delegation to other organization.
33-10-107. Tax exemption.
33-10-108. Prevention of insolvencies — directors' and commissioner's action.
33-10-109. Notice of insolvencies — suspension — other powers and duties of commissioner.
33-10-110. Immunity.
33-10-111. Stay of proceedings — reopening of default judgments.
33-10-112. Examination of association.
33-10-113. Claims — notice.
33-10-114. Claims — effect as to insured and receiver.
33-10-115. Recovery — sequence — nonduplication.
33-10-116. Assessment.
33-10-117. Recognition of assessments in rates.

Part 2 — Life and Health Insurance Guaranty Associations

33-10-201. Short title, purpose, and construction.
33-10-202. Definitions.
33-10-203. Creation of association — accounts — supervision by commissioner.
33-10-204. Board of directors — commissioner approval — compensation.
33-10-205. Powers and duties of association.
33-10-206. Records of meetings and negotiations.
33-10-207. Immunity.
33-10-208. Tax exemptions.
33-10-209. Examination of the association — annual report.
33-10-210. Unfair trade practice — notice to policyowners.
33-10-211 through 33-10-214 reserved.
33-10-215. Duties and powers of commissioner.
33-10-216. Plan of operation — delegation of powers provision.
33-10-217. Prevention of insolvencies or impairments.
33-10-218. Examination by commissioner — cost.
33-10-219. Repealed.
33-10-220. Repealed.
33-10-221. Nomination of liquidator by association — notification given by liquidator.
33-10-222. Stay of proceedings — reopening default judgments.
33-10-223. Assignment by beneficiaries — subrogation.
33-10-224. Coverage, limitations, and extent of liability.
33-10-225. Association as creditor — use of assets.
33-10-226. Distribution of ownership rights — distribution to shareholders.
33-10-227. Assessments — abatement — basis for ratesetting.
33-10-228. Repealed.
33-10-229. Repealed.
33-10-230. Tax — writeoffs of certificates of contribution.
33-10-231 through 33-10-234 reserved.
33-10-235. Association election to continue reinsurance.
33-10-236. Deposits paid to association.

Part 1
Casualty and Property Insurance Guaranty Associations

Part Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.
Montana Self-Insurers Guaranty Fund Act, Title 39, ch. 71, part 26.

33-10-101. Short title, purpose, scope, and construction. (1) This part shall be known and may be cited as the "Montana Insurance Guaranty Association Act".

(2) The purpose of this part is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers.

(3) This part shall apply to all kinds of direct insurance, except life, title, surety, disability, credit, mortgage guaranty, and ocean marine insurance.

(4) This part shall be liberally construed to effect the purpose under subsection (2) which shall constitute an aid and guide to interpretation.

History: En. Secs. 1, 2, 3, 4, Ch. 63, L. 1971; R.C.M. 1947, 40-5701, 40-5702, 40-5703, 40-5704; amd. Sec. 3, Ch. 139, L. 1987.

Cross-References

Types of insurance — definitions, 33-1-205 through 33-1-212.

33-10-102. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the Montana insurance guaranty association created under 33-10-103.

(2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, that arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part applies issued by an insurer, if the insurer becomes an insolvent insurer after July 1, 1971, and:

(i) the claimant or insured is a resident of this state at the time of the insured event; or

(ii) the property from which the claim arises is permanently located in this state.

(b) Covered claim does not include any amount:

(i) awarded as punitive or exemplary damages;

(ii) sought as a return of premium under a retrospective rating plan; or

(iii) due a reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries, reinsurance recoveries, contribution, or indemnification. A reinsurer, insurer, insurance pool, or underwriting association may not assert a claim for any amount against the insured of the insolvent insurer other than to the extent that the claim exceeds the policy limits of the insolvent insurer's policy.

(3) "Insolvent insurer" means an insurer:

(a) authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred; and

(b) against whom an order of liquidation has been entered with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(4) "Member insurer" means a person who:

(a) writes any kind of insurance to which this part applies under 33-10-101(3), including the exchange of reciprocal or interinsurance contracts; and

(b) is licensed to transact insurance in this state.

(5) (a) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums on the policies and dividends paid or credited to policyholders of policies to which this part applies.

(b) Net direct written premiums does not include premiums on contracts between insurers or reinsurers.

(6) "Person" means any individual, corporation, partnership, association, or voluntary organization.

History: En. Sec. 5, Ch. 63, L. 1971; R.C.M. 1947, 40-5705(1), (3) thru (7); amd. Sec. 24, Ch. 472, L. 1999; amd. Sec. 35, Ch. 227, L. 2001; amd. Sec. 17, Ch. 380, L. 2003.

33-10-103. Creation of the association. There is created a nonprofit unincorporated legal entity to be known as the Montana insurance guaranty association. All insurers defined as member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under 33-10-106 and shall exercise its powers through a board of directors established under 33-10-104.

History: **En. Sec. 6, Ch. 63, L. 1971; R.C.M. 1947, 40-5706.**

33-10-104. Board of directors — commissioner approval — compensation. (1) The board of directors of the association consists of not less than seven or more than nine persons serving terms as established in the plan of operation. Two of the members must be appointed from the public at large by the commissioner. The other members of the board must be member insurers and must be selected by member insurers subject to the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term in the same manner as initial appointments.

(2) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

History: **En. Sec. 7, Ch. 63, L. 1971; R.C.M. 1947, 40-5707(part); amd. Sec. 1, Ch. 65, L. 1995; amd. Sec. 10, Ch. 169, L. 2013.**

33-10-105. General powers and duties. (1) Subject to subsection (2), the association:

(a) (i) is obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within 30 days after the determination of insolvency or before the policy expiration date if less than 30 days after the determination or before the insured replaces the policy or causes its cancellation if the insured does so within 30 days of the determination;

(ii) is obligated under subsection (1)(a)(i) only for that amount of each covered claim that does not exceed $300,000, except that:

(A) the association shall pay an amount not exceeding $10,000 for each policy for a covered claim for the return of unearned premium; and

(B) the association shall pay the full amount of any covered claim arising out of a workers' compensation or excess workers' compensation policy; and

(iii) is not obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises;

(b) is considered the insurer to the extent of its obligation on the covered claims and to that extent has all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(c) shall investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases, and judgments may be properly contested;

(d) shall notify persons as the commissioner directs under 33-10-109(2)(a), including the department of labor and industry for workers' compensation claims;

(e) shall handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer.

(f) shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this part.

(2) (a) Except as provided in subsection (2)(b), a covered claim may not include a claim filed with the association or a liquidator for protection under the insured's policy for losses incurred but not reported and may not include a claim filed with the association after the earlier of:

(i) 36 months after the date of the order of liquidation; or

(ii) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

(b) (i) If the claimant learns that the claimant's condition resulted from an occupational disease compensable under Title 39, chapter 71, within 36 months of the order of liquidation or the final date set by the court for the filing of claims against the liquidator, the claimant shall file a claim, which must be paid under the terms of subsection (1)(a). If the claimant does not learn of a compensable condition under Title 39, chapter 71, until after the time specified in either subsection (2)(a)(i) or (2)(a)(ii) has expired, the claimant shall file a claim with the association within 1 year from the date the claimant knew or should have known that the claimant's condition resulted from an occupational disease.

(ii) Notice by a claimant or insurer to the department of labor and industry of a workers' compensation claim or an occupational disease claim pursuant to Title 39, chapter 71, constitutes notice to the liquidator for the purposes of workers' compensation or occupational disease claims.

(3) The association may:

(a) employ or retain persons necessary to handle claims and perform other duties of the association;

(b) borrow funds necessary to effect the purposes of this part in accord with the plan of operation;

(c) sue or be sued;

(d) negotiate and become a party to contracts necessary to carry out the purpose of this part;

(e) perform other acts necessary or proper to effectuate the purpose of this part;

(f) refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

History: En. Sec. 8, Ch. 63, L. 1971; R.C.M. 1947, 40-5708(part); amd. Sec. 53, Ch. 596, L. 1993; amd. Sec. 1, Ch. 29, L. 2005; amd. Sec. 1, Ch. 195, L. 2005; amd. Sec. 41, Ch. 416, L. 2005; amd. Sec. 13, Ch. 63, L. 2015.

Cross-References

Standing — rehabilitation or liquidation proceedings, 33-2-1335, 33-2-1349.

33-10-106. Plan of operation — delegation to other organization. (1) (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan of operation that are necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments to the plan become effective upon approval in writing by the commissioner.

(b) If at any time the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate reasonable rules that are necessary or advisable to effectuate the provisions of this part. The rules continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation must:

(a) establish the procedures under which all the powers and duties of the association under 33-10-105 and 33-10-116 will be performed;

(b) establish procedures for handling assets of the association;

(c) establish the amount and method of reimbursing members of the board of directors under 33-10-104;

(d) establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims;

(e) establish regular places and times for meetings of the board of directors;

(f) establish procedures for records to be kept of all financial transactions of the association, its insurance producers, and the board of directors;

(g) provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within 30 days after the action or decision;

(h) establish the procedures under which selections for the board of directors will be submitted to the commissioner;

(i) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under 33-10-105(3)(b) and 33-10-116, are delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association or its equivalent in two or more states. A corporation, association, or organization must be reimbursed as a servicing facility would be reimbursed and must be paid for its performance of any other functions of the association. A delegation under this subsection takes effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this part.

History: En. Sec. 9, Ch. 63, L. 1971; R.C.M. 1947, 40-5709(part); amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 35, Ch. 44, L. 2007.

Cross-References

Notice and hearing by Commissioner, 33-1-313.

33-10-107. Tax exemption. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

History: En. Sec. 15, Ch. 63, L. 1971; R.C.M. 1947, 40-5715.

Cross-References

Property subject to taxation, Title 15, ch. 6.

33-10-108. Prevention of insolvencies — directors' and commissioner's action. (1) It is the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating that any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

(2) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer that the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within 30 days of the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by persons that the commissioner designates. The cost of the examination must be paid by the association, and the examination report must be treated as are other examination reports. The examination report may not be released to the board of directors prior to its release to the public, but this does not preclude the commissioner from complying with subsection (3). The commissioner shall notify the board of directors when the examination is completed. The request for an examination must be kept on file by the commissioner, but it may not be open to public inspection prior to the release of the examination report to the public.

(3) It is the duty of the commissioner to report to the board of directors when the commissioner has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public.

(4) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or supervision of any member insurer. The reports and recommendations may not be considered public documents.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(6) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of the insolvency, based on the information available to the association, and submit the report to the commissioner.

History: En. Sec. 13, Ch. 63, L. 1971; R.C.M. 1947, 40-5713; amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 1177, Ch. 56, L. 2009.

Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.

33-10-109. Notice of insolvencies — suspension — other powers and duties of commissioner. (1) The commissioner shall:

(a) notify the association of the existence of an insolvent insurer not later than 3 days after the commissioner receives notice of the determination of the insolvency;

(b) upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(2) The commissioner may:

(a) require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this part. The notification must be by mail at their last-known addresses, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation is sufficient.

(b) suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer that fails to pay an assessment when due. The fine may not exceed 5% of the unpaid assessment a month, except that a fine may not be less than $100 a month.

(c) revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(3) Any final action or order of the commissioner under this part must be subject to judicial review in a court of competent jurisdiction.

History: En. Sec. 10, Ch. 63, L. 1971; R.C.M. 1947, 40-5710; amd. Sec. 1178, Ch. 56, L. 2009.

Cross-References

Revocation or suspension of certificate of authority, 33-2-118, 33-2-119.

33-10-110. Immunity. There is not any liability on the part of and a cause of action of any nature may not be brought against any member insurer or its agents or employees, the association or the association's agents or employees, the board of directors, or the commissioner or the commissioner's representatives for any action taken by them in the performance of their powers and duties under this part.

History: En. Sec. 17, Ch. 63, L. 1971; R.C.M. 1947, 40-5717; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 2, Ch. 29, L. 2005.

33-10-111. Stay of proceedings — reopening of default judgments. (1) All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state must be stayed for 6 months from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, or must be stayed for any additional time as may be determined by the court in order to permit proper defense by the association of all pending causes of action.

(2) As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and must be permitted to defend against the claim on the merits.

History: En. Sec. 18, Ch. 63, L. 1971; R.C.M. 1947, 40-5718; amd. Sec. 54, Ch. 596, L. 1993.

Cross-References

Standing of associations, 33-2-1335, 33-2-1349.

33-10-112. Examination of association. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

History: En. Sec. 14, Ch. 63, L. 1971; R.C.M. 1947, 40-5714.

33-10-113. Claims — notice. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its insurance producer, and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

History: En. Sec. 9, Ch. 63, L. 1971; R.C.M. 1947, 40-5709(part); amd. Sec. 1, Ch. 713, L. 1989.

33-10-114. Claims — effect as to insured and receiver. (1) Any person recovering under this part is considered to have assigned the person's rights under the policy to the association to the extent of the person's recovery from the association. Every insured or claimant seeking the protection of this part shall cooperate with the association to the same extent that the person would have been required to cooperate with the insolvent insurer. The association does not have a cause of action against the insured of the insolvent insurer for any sums it has paid out except causes of action that the insolvent insurer would have had if the sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association may not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(2) The association has the right to recover from the following persons the amount of any "covered claim" paid on behalf of the person pursuant to this part:

(a) any insured whose net worth, on December 31 of the year preceding the date the insurer becomes an insolvent insurer, exceeds $50 million and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part; and

(b) any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this part.

(3) The receiver, liquidator, or statutory successor of an insolvent insurer is bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant the claims priority equal to that which the claimant would have been entitled in the absence of this part against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims must be accorded the same priority as the liquidator's expenses.

(4) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association which shall preserve the rights of the association against the assets of the insolvent insurer.

History: En. Sec. 11, Ch. 63, L. 1971; R.C.M. 1947, 40-5711; amd. Sec. 55, Ch. 596, L. 1993.

Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.
Standing of associations, 33-2-1335, 33-2-1349.
Priority of association's claims, 33-2-1363.

33-10-115. Recovery — sequence — nonduplication. (1) Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer that is also a covered claim must be required to exhaust the person's right under the policy. Any amount payable on a covered claim under this part must be reduced by the amount of any recovery under the insurance policy.

(2) Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property, and if it is a workers' compensation claim, the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this part must be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

History: En. Sec. 12, Ch. 63, L. 1971; R.C.M. 1947, 40-5712; amd. Sec. 1179, Ch. 56, L. 2009.

33-10-116. Assessment. (1) The association shall assess insurers amounts necessary to pay the obligations of the association under 33-10-105(1)(a) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under 33-10-108, and other expenses authorized by this part.

(2) The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bear to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than 30 days before it is due. No member insurer may be assessed in any year an amount greater than 2% of that member insurer's net direct written premiums for the preceding calendar year.

(3) If the maximum assessment together with the other assets of the association does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available.

(4) The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance.

(5) Each member insurer may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.

History: **En. Sec. 8, Ch. 63, L. 1971; R.C.M. 1947, 40-5708(1)(c).**

33-10-117. Recognition of assessments in rates. The rates and premiums charged for insurance policies to which this part applies shall include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association, and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

History: **En. Sec. 16, Ch. 63, L. 1971; R.C.M. 1947, 40-5716.**

Part 2
Life and Health Insurance Guaranty Associations

Part Cross-References

Supervision, rehabilitation, and liquidation of insurers, Title 33, ch. 2, part 13.

Montana Self-Insurers Guaranty Fund Act, Title 39, ch. 71, part 26.

33-10-201. Short title, purpose, and construction. (1) This part may be cited as the "Montana Life and Health Insurance Guaranty Association Act".

(2) The purpose of this part is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the insurer issuing the policies or contracts.

(3) To provide this protection:

(a) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages;

(b) members of the association are subject to assessment to provide funds to carry out the purpose of this part; and

(c) the association is authorized to assist the commissioner, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

(4) This part must be liberally construed to effect the purpose under subsections (2) and (3), which constitute an aid and guide to interpretation.

(5) This part may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

History: **En. 40-5801 thru 40-5804, 40-5814 by Secs. 1 thru 4, 14, Ch. 245, L. 1974; R.C.M. 1947, 40-5801, 40-5802, 40-5803, 40-5804, 40-5814(1); amd. Sec. 1, Ch. 576, L. 1987; amd. Sec. 56, Ch. 596, L. 1993; amd. Sec. 39, Ch. 379, L. 1995; amd. Sec. 3, Ch. 195, L. 2003; amd. Sec. 1, Ch. 27, L. 2011.**

33-10-202. Definitions. As used in this part, the following definitions apply:

(1) "Account" means either of the two accounts created under 33-10-203.

(2) "Association" means the Montana life and health insurance guaranty association created under 33-10-203.

(3) "Authorized assessment" or "authorized" when used in the context of assessments means a specified amount of money authorized for collection from member insurers by a resolution of the board of directors established in 33-10-204. The authorized assessment may be called for immediately or in the future. The assessment is authorized when the board passes the resolution.

(4) "Benefit plan" means a benefit plan for a specific employee, union, or association of natural persons.

(5) "Called", when used in the context of assessments, means that the association has issued a notice to member insurers requiring that an authorized assessment be paid within the timeframe set forth within the notice. An authorized assessment becomes a called assessment when the association mails the notice to member insurers.

(6) "Contractual obligation" means an obligation under any of the following for which coverage is provided in this part:

(a) a policy or contract;

(b) a certificate under a group policy or contract; or

(c) a portion of a policy or contract or a portion of a certificate.

(7) "Covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided within the scope of this part.

(8) "Extracontractual claims" includes but is not limited to those claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorney fees and costs.

(9) "Health insurance coverage" has the same meaning as provided in 33-22-140, except that the term does not include excepted benefits as defined in 33-22-140.

(10) "Impaired insurer" means a member insurer that is not an insolvent insurer and that is placed under an order of rehabilitation or supervision by a court of competent jurisdiction.

(11) "Insolvent insurer" means a member insurer that is placed under an order of liquidation by a court of competent jurisdiction upon a finding of insolvency.

(12) "Long-term care insurance" has the same meaning as provided in 33-22-1107.

(13) (a) "Member insurer" means an insurer, health service corporation, or health maintenance organization that is licensed or that holds a certificate of authority to transact any kind of insurance in this state for which coverage is provided under this part and includes any insurer, health service corporation, or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The term does not include:

(i) a hospital or medical service organization, whether for profit or not for profit;

(ii) a fraternal benefit society;

(iii) a mandatory state pooling plan;

(iv) a mutual assessment company or any other person that operates on an assessment basis;

(v) an insurance exchange;

(vi) a multiple employer welfare arrangement as defined in 29 U.S.C. 1002;

(vii) an organization that has a certificate or license limited to the issuance of charitable gift annuities; or

(viii) an entity similar to any of the entities listed in subsections (13)(b)(i) through (13)(b)(vii).

(14) "Moody's corporate bond yield average" means the monthly average corporates as published by Moody's investors service, inc., or its successor.

(15) (a) "Owner", "contract owner", and "policyowner" mean the person who is identified as the legal owner under the terms of a policy or contract or who is vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and who is properly recorded as the owner on the books of the insurer.

(b) The terms do not include a person with a mere beneficial interest in a policy or a contract.

(16) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(17) "Plan sponsor" means:

(a) the employer in the case of a benefit plan established or maintained by a single employer;

(b) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(c) in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(18) (a) "Premiums" means the amount or consideration received on covered policies or contracts less return premiums, considerations, and deposits, and less dividends and experience credits.

(b) The term does not include:

(i) amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided pursuant to this part, except that an assessable premium may not be reduced based on 33-10-224(2)(b) relating to interest limitations and 33-10-224(3)(b) relating to one individual, one participant, and one contract owner;

(ii) premiums in excess of $5 million on an unallocated annuity contract not issued under a governmental retirement benefit plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code; or

(iii) premiums in excess of $5 million with respect to multiple nongroup policies of life insurance owned by one owner, whether the policyowner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, regardless of the number of policies or contracts held by the owner.

(19) "Principal place of business" means:

(a) in the case of a plan sponsor, the state in which more than 50% of the participants in the benefit plan are employed;

(b) if 50% of the participants of a benefit plan are not employed in a single state and for a person other than an individual, the single state in which the individuals who establish policies for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, as determined by the association in its reasonable judgment by considering the following factors:

(i) the state in which the primary executive and administrative headquarters is located;

(ii) the state in which the principal office of the chief executive officer is located;

(iii) the state in which the board of directors or similar governing persons conduct its meetings;

(iv) the state in which the executive or management committee of the board of directors or similar governing person or persons conduct the majority of their meetings;

(v) the state from which the management of the overall operations is directed; and

(vi) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors; or

(c) with respect to a plan sponsor defined in subsection (17)(c), the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of specific or clear designation of a principal place of business, is the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(20) "Receivership court" means the court in the insolvent or impaired insurer's state that has jurisdiction over the supervision, rehabilitation, or liquidation of the insurer.

(21) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, and in the case of a person other than an individual, the person is a resident of the state where its principal place of business is located. Citizens of the United States who are either residents of foreign countries or residents of the possessions, territories, or protectorates of the United States and who do not have an association similar to the association created by this part must be considered residents of the state of domicile of the insurer that issued the policies or contracts.

(22) "State" means a state, the District of Columbia, the Commonwealth of Puerto Rico, or a United States possession, territory, or protectorate.

(23) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(24) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract.

(25) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by the insurer under the contract or certificate.

History: En. 40-5805 by Sec. 5, Ch. 245, L. 1974; R.C.M. 1947, 40-5805(1), (2), (4) thru (10); amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 2, Ch. 576, L. 1987; amd. Sec. 57, Ch. 596, L. 1993; amd. Sec. 40, Ch. 379, L. 1995; amd. Sec. 145, Ch. 42, L. 1997; amd. Sec. 20, Ch. 531, L. 1997; amd. Sec. 4, Ch. 195, L. 2003; amd. Sec. 2, Ch. 27, L. 2011; amd. Sec. 1, Ch. 25, L. 2019.

33-10-203. Creation of association — accounts — supervision by commissioner. (1) There is created a nonprofit legal entity to be known as the Montana life and health insurance guaranty association. A member insurer must be and remain a member of the association as a condition of the member's authority to transact insurance in this state. The association shall perform functions under the plan of operation established and approved under 33-10-216 and shall exercise powers through a board of directors established under 33-10-204.

(2) For purposes of administration and assessment, the association shall maintain two accounts:

(a) the health insurance account; and

(b) the life insurance and annuity account that includes the following subaccounts:

(i) the life insurance account;

(ii) the annuity account that includes contracts owned by a governmental retirement plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code, but does not otherwise include unallocated annuities; and

(iii) the unallocated annuity account that must exclude unallocated annuity contracts owned by a governmental retirement benefit plan or the plan's trustee established under section 401, 403(b), or 457 of the Internal Revenue Code.

(3) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state.

History: En. 40-5806 by Sec. 6, Ch. 245, L. 1974; R.C.M. 1947, 40-5806; amd. Sec. 58, Ch. 596, L. 1993; amd. Sec. 5, Ch. 195, L. 2003; amd. Sec. 9, Ch. 469, L. 2005.

Cross-References

Types of insurance — definitions, 33-1-205 through 33-1-212.

33-10-204. Board of directors — commissioner approval — compensation. (1) The board of directors of the association consists of not less than seven or more than nine members serving terms as established in the plan of operation. Two of the members must be appointed from the public at large by the commissioner. The other members of the board must be selected by member insurers subject to the approval of the commissioner. Vacancies on the board must be filled for the remaining period of the term in the manner described in the plan of operation. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(2) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board may not otherwise be compensated by the association for their services. However, any designated representatives of members of the board who are not full-time employees of the member insurers that designated them may receive reasonable compensation for their services on the board of directors upon annual approval by the members of the association.

History: En. 40-5807 by Sec. 7, Ch. 245, L. 1974; R.C.M. 1947, 40-5807(part); amd. Sec. 3, Ch. 576, L. 1987; amd. Sec. 2, Ch. 65, L. 1995; amd. Sec. 15, Ch. 157, L. 2023.

33-10-205. Powers and duties of association. (1) If a member insurer is an impaired insurer, the association, in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner, may:

(a) guarantee, assume, reissue, reinsure, or cause to be guaranteed, assumed, reissued, or reinsured any or all of the policies or contracts of the impaired insurer; and

(b) provide any money, pledges, loans, notes, guarantees, or other means to effectuate this section and ensure payment of the contractual obligations of the impaired insurer pending action under this section.

(2) If a member insurer is an insolvent insurer, the association, in its discretion, shall do one or more of the following:

(a) (i) guarantee, assume, reissue, or reinsure the policies or contracts of the insolvent insurer, cause the policies or contracts to be guaranteed, assumed, reissued, or reinsured, or ensure payment of the contractual obligations of the insolvent insurer; and

(ii) provide money, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties;

(b) provide coverage and benefits with respect to a covered policy or contract for life or health insurance or annuities by:

(i) ensuring payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(A) for group policies or contracts by not later than the earlier of the next renewal date, as specified in the policy or contract, or 45 days; or

(B) for nongroup policies, contracts, or annuities by the earlier of the next renewal date, if any, as specified in the policy or contract, or 1 year;

(ii) ensuring payment under subsection (2)(b)(i) not less than 30 days from the date on which the association becomes obligated with respect to the policies or contracts;

(iii) making diligent efforts to provide all known insureds and annuitants for nongroup policies and contracts or group policyowners with respect to group policies 30 days' notice of termination; and

(iv) (A) making available substitute coverage on an individual basis, with respect to nongroup life and health insurance policies and annuities covered by the association, to each known insured or annuitant or owner if other than the insured or annuitant and to an individual formerly insured or formerly an annuitant under a group policy if that individual is not eligible for replacement group coverage. This subsection (2)(b)(iv)(A) must be applied in accordance with the provisions of subsection (2)(b)(iv)(B), as applicable, if the insureds or annuitants had a right under law or if the terminated policy or annuity contained provisions to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or a specified time, during which the insurer had no right to unilaterally make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

(B) providing the substitute coverage required under subsection (2)(b)(iv)(A) either by issuing an alternative policy as provided in subsection (2)(b)(iv)(C) or reissuing the terminated coverage, as provided in subsection (2)(b)(iv)(D). Any reissued or alternative policy must be offered without requiring evidence of insurability and may not require a waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure any reissued or alternative policy.

(C) submitting alternative policies or contracts adopted by the association to the commissioner for approval. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency. Alternative policies must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium must be actuarially justified and reflect the amount of insurance to be provided and the age and class of risk of each insured. The premium may not reflect any changes in the health of the insured after the original policy was last underwritten. Alternative policies issued by the association must provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(D) setting a premium at a premium different from that charged under the terminated policy if the association elects to reissue terminated coverage. The association shall set the premium in accordance with the amount of insurance provided and the age and class of risk. The premium must be actuarially justified and is subject to approval by the commissioner. A premium may also be set by a court of competent jurisdiction.

(c) cease any of its obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy on the date the coverage or policy is replaced by another similar policy by the policyowner, the insured, or the association; or

(d) ensure the payment or crediting of a rate of interest consistent with 33-10-224(2)(b)(iii) when proceeding under this section with respect to a policy or contract carrying guaranteed minimum interest rates.

(3) Except for claims incurred or any net cash surrender value that may be due in accordance with the provisions of this part, the association's obligation under the policy or contract terminates within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage for nonpayment of premiums.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association. The association is liable only for unearned premiums due to policyowners or contract owners arising after the entry of the order of liquidation.

(5) If the association fails to act within a reasonable period of time, the commissioner has the powers and duties of the association under this part with respect to a domestic, foreign, or alien insolvent insurer.

(6) (a) In carrying out its duties under subsections (1) through (4), the association may, subject to approval by a court of competent jurisdiction, impose:

(i) permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement if the association finds that:

(A) the amounts that can be assessed under this part are less than the amounts needed to ensure full and prompt performance of the association's duties under this part; or

(B) the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of permanent policy or contract liens to be in the public interest; or

(ii) temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts. This subsection (6)(a)(ii) also allows temporary moratoriums or liens on any contractual provisions for deferral of cash or policy loan value.

(b) If the receivership court imposes a temporary moratorium or moratorium charge on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights for the period of the moratorium or moratorium charge imposed by the receivership court. This subsection (6)(b) does not apply to claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) The association is not liable under this part for any covered policy of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides protection by statute or regulation for residents of this state if that protection is substantially similar to that provided by this part for residents of other states.

(8) In carrying out its duties under this section, the association may, subject to the approval of the commissioner, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed for calculating returns or changes in value. The alternative policy or contract issued under this subsection (8):

(a) must provide in lieu of the index or other external reference in the original policy or contract:

(i) a fixed interest rate;

(ii) payment of dividends within minimum guarantees; or

(iii) a different method for calculating interest or changes in value;

(b) may not contain a requirement for evidence of insurability, a waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(c) must be substantially similar to the replaced policy or contract in all other material terms.

(9) In addition to other rights provided by law, the association may:

(a) enter into contracts that are necessary or proper to carry out the provisions and purposes of this part;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments and to settle claims or potential claims against it;

(c) borrow money to effect the purposes of this part. Any notes or other evidence of indebtedness of the association not in default must be legal investments for domestic insurers and may be carried as admitted assets.

(d) employ or retain persons who are necessary to handle the financial transactions of the association and to perform other functions that become necessary or proper under this part;

(e) negotiate and contract with any liquidator, rehabilitator, supervisor, or ancillary receiver to carry out the powers and duties of the association;

(f) take legal action that may be necessary or appropriate to avoid or recover payment of improper claims;

(g) exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but the association may not issue insurance policies or annuity contracts other than those issued to perform its obligations under this part;

(h) organize itself as a corporation or in any other legal form permitted by the laws of the state;

(i) request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this part with respect to the person. The person shall promptly comply with the request.

(j) unless prohibited or otherwise limited by another section in this title and in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this part; and

(k) take other necessary or appropriate action to discharge its duties and obligations under this part or to exercise its powers under this part.

(10) The association may render assistance and advice to the commissioner, upon request, concerning rehabilitation, liquidation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(11) The association has standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part or before any court with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. The association's standing extends to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring, modifying, or guaranteeing the covered policies or contracts of the impaired or insolvent insurer and the determination of the covered policies or contracts. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or before a court with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise.

(12) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(13) The board of directors of the association may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(14) When the association has arranged or offered to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(15) Venue in a suit against the association arising under this part is in the first judicial district of this state. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

(16) The protection provided by this part does not apply when any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer that is other than this state.

History: **En. 40-5808 by Sec. 8, Ch. 245, L. 1974; R.C.M. 1947, 40-5808(7), (8), (11); amd. Sec. 6, Ch. 195, L. 2003; amd. Sec. 3, Ch. 27, L. 2011; amd. Sec. 2, Ch. 25, L. 2019.**

Cross-References

Standing — rehabilitation or liquidation proceedings, 33-2-1335, 33-2-1349.

33-10-206. Records of meetings and negotiations. Records must be kept of all negotiations and meetings of the board of directors held to discuss the activities of the association in carrying out its powers and duties under this part. Records of negotiations or meetings pertaining to an impaired or insolvent insurer may be made public only upon the termination of a liquidation, rehabilitation, or supervision proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. This section does not limit the duty of the association to render a report of its activities under 33-10-209.

History: **En. 40-5814 by Sec. 14, Ch. 245, L. 1974; R.C.M. 1947, 40-5814(2); amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 7, Ch. 195, L. 2003.**

33-10-207. Immunity. There is not any liability on the part of and a cause of action of any nature may not be brought against any member insurer or its agents or employees, the association or the association's agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives for any action taken by them in the performance of their powers and duties under this part.

History: **En. 40-5818 by Sec. 18, Ch. 245, L. 1974; R.C.M. 1947, 40-5818; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 8, Ch. 195, L. 2003; amd. Sec. 18, Ch. 380, L. 2003.**

33-10-208. Tax exemptions. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real property.

History: **En. 40-5816 by Sec. 16, Ch. 245, L. 1974; R.C.M. 1947, 40-5816.**

Cross-References

Property subject to taxation, Title 15, ch. 6.

33-10-209. Examination of the association — annual report. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of its activities during the preceding calendar year.

History: **En. 40-5815 by Sec. 15, Ch. 245, L. 1974; R.C.M. 1947, 40-5815.**

Cross-References

Examination by Commissioner, Title 33, ch. 1, part 4.

33-10-210. Unfair trade practice — notice to policyowners. (1) It is a prohibited unfair trade practice for any person to make use in any manner of the protection afforded by this part in the sale of insurance.

(2) The association shall prepare a summary document, complying with subsection (3) and describing the general purposes and current limitations of this part. The document must be submitted to the commissioner for approval. Sixty days after receiving approval, a member insurer may not deliver a policy or contract described in 33-10-224(2)(a) to a policyowner or contract owner unless the document is delivered to the policyowner or contract owner prior to or at the time of delivery of the policy or contract. The document must be available upon request by a policyowner. The distribution, delivery, contents, or interpretation of this document does not mean that either the policy or the contract or the owner of the policy or contract would be covered in the event of the impairment or insolvency of a member insurer. The description document must be revised by the association as amendments to this part may require. Failure to receive this document does not give the policyowner, contract owner, certificate holder, or insured any greater rights than those stated in this part.

(3) The document prepared under subsection (2) must contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer must:

(a) state the name and address of the life and health insurance guaranty association and insurance department;

(b) prominently warn the policyowner or contract owner that the life and health insurance guaranty association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(c) state that the insurer and its insurance producers are prohibited by law from using the existence of the life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(d) emphasize that the policyowner or contract owner should not rely on coverage under the life and health insurance guaranty association when selecting an insurer;

(e) provide other information as directed by the commissioner.

History: **En. 40-5814 by Sec. 14, Ch. 245, L. 1974; R.C.M. 1947, 40-5814(5); amd. Sec. 59, Ch. 596, L. 1993; amd. Sec. 9, Ch. 195, L. 2003; amd. Sec. 4, Ch. 27, L. 2011; amd. Sec. 3, Ch. 25, L. 2019.**

Cross-References

Unfair trade practices, Title 33, ch. 18.

33-10-211 through 33-10-214 reserved.

33-10-215. Duties and powers of commissioner. (1) In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

(a) notify the board of directors of the existence of an impaired or insolvent insurer after an order of impairment or insolvency is entered or the commissioner receives notice of impairment or insolvency;

(b) upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer;

(c) when an impairment or insolvency is declared and the amount of the impairment or insolvency is determined, serve a demand upon the impaired or insolvent insurer to make good the impairment or insolvency within a reasonable time. Notice to the impaired or insolvent insurer constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with the demand does not excuse the association from the performance of its powers and duties under this part.

(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer that fails to pay an assessment when due. The fine may not exceed 5% of the unpaid assessment per month, except that the fine may not be less than $100 per month.

(3) A final action of the board of directors may be appealed to the commissioner by a member insurer if the appeal is taken within 60 days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(4) The liquidator, rehabilitator, or conservator of an impaired or insolvent insurer may notify all affected persons of the effect of this part.

History: **En. 40-5811 by Sec. 11, Ch. 245, L. 1974; R.C.M. 1947, 40-5811(1); amd. Sec. 10, Ch. 195, L. 2003; amd. Sec. 4, Ch. 25, L. 2019.**

Cross-References

Liquidation or rehabilitation proceedings, Title 33, ch. 2, part 13.

33-10-216. Plan of operation — delegation of powers provision. (1) (a) The association shall submit to the commissioner a plan of operation and any amendments to the plan that are necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments to the plan become effective upon the commissioner's written approval or 60 days after receipt by the commissioner's office if the commissioner does not disapprove the submitted plan of operation and any amendments within those 60 days.

(b) If the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate reasonable rules necessary or advisable to effectuate the provisions of this part. The rules remain in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation must, in addition to requirements enumerated elsewhere in this part:

(a) establish procedures for handling the assets of the association;

(b) establish the amount and method of reimbursing members of the board of directors under 33-10-204;

(c) establish regular places and times for meetings of the board of directors;

(d) establish procedures for keeping records of all financial transactions of the association, its agents, and the board of directors;

(e) establish procedures to select the board of directors and submit notice of the selections to the commissioner;

(f) establish any additional procedures for assessments under 33-10-227;

(g) establish procedures for the removal of a director for cause, including in a case in which a member insurer director becomes an impaired or insolvent insurer;

(h) require the board of directors to establish a policy and procedures for addressing conflicts of interests;

(i) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under 33-10-205(9)(c) and 33-10-227, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this association or its equivalent in two or more states. A corporation, association, or organization to which these powers and duties are delegated must be reimbursed for any payments made on behalf of the association and must be paid for performing any function of the association. A delegation of authority under this subsection may take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization that extends protection not substantially less favorable or less effective than that provided by this part.

History: **En. 40-5810 by Sec. 10, Ch. 245, L. 1974; R.C.M. 1947, 40-5810; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 5, Ch. 27, L. 2011; amd. Sec. 5, Ch. 25, L. 2019.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

Promulgation of rules by Commissioner, 33-1-313.

33-10-217. Prevention of insolvencies or impairments. (1) To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner shall:

(a) (i) notify the commissioners of all the other states when the commissioner takes any of the following actions against a member insurer:

(A) the revocation of a license;

(B) the suspension of a license; or

(C) the issuance of any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyowners or creditors;

(ii) mail the notice to all commissioners within 30 days following the action taken or the date on which the action occurs;

(b) report to the board of directors when the commissioner has taken any of the actions set forth in subsection (1)(a) or has received a report from any other commissioner indicating that an action has been taken in another state. The report to the board of directors must contain all significant details of the action taken or the report received from another commissioner.

(c) report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer; and

(d) furnish to the board of directors the national association of insurance commissioners' insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners. The board of directors may use the information contained in the ratios and listings in carrying out its duties and responsibilities under this section. The report and the information contained in the ratios and listings must be kept confidential by the board of directors until the commissioner or other lawful authority makes the report or information public.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(3) The board of directors shall, upon majority vote, notify the commissioner of any information indicating any member insurer may be unable or potentially unable to fulfill its contractual obligations.

(4) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be unable or potentially unable to fulfill its contractual obligations.

(5) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or supervision of any member insurer or germane to the solvency of any company seeking to provide life or health insurance in this state. The reports and recommendations are not considered public documents.

(6) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer impairments or insolvencies.

History: En. 40-5812 by Sec. 12, Ch. 245, L. 1974; R.C.M. 1947, 40-5812(part); amd. Sec. 17, Ch. 198, L. 1979; amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 60, Ch. 596, L. 1993; amd. Sec. 11, Ch. 195, L. 2003; amd. Sec. 6, Ch. 27, L. 2011.

33-10-218. Examination by commissioner — cost. (1) The commissioner may conduct the examination requested by the board pursuant to 33-10-217(4). The examination may be conducted as a national association of insurance commissioners examination or may be conducted by persons whom the commissioner designates. The cost of the examination must be paid by the association, and the examination report must be treated as are other examination reports.

(2) The examination report may not be released to the board of directors of the association prior to its release to the public, but this may not excuse the commissioner from the obligation to comply with subsection (4). The commissioner shall notify the board of directors when the examination is completed.

(3) The request for an examination must be kept on file by the commissioner, but it may not be open to public inspection prior to the release of the examination report to the public and must be released at that time only if the examination discloses that the examined insurer is unable or potentially unable to meet its contractual obligations.

(4) The commissioner shall report to the board of directors when the commissioner has reasonable cause to believe that any member insurer examined at the request of the board of directors may be unable or potentially unable to fulfill its contractual obligations.

History: En. 40-5812 by Sec. 12, Ch. 245, L. 1974; R.C.M. 1947, 40-5812(part); amd. Sec. 61, Ch. 596, L. 1993.

33-10-219. Repealed. Sec. 13, Ch. 27, L. 2011.

History: En. 40-5808 by Sec. 8, Ch. 245, L. 1974; R.C.M. 1947, 40-5808(1), (2); amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 4, Ch. 576, L. 1987; amd. Sec. 12, Ch. 195, L. 2003.

33-10-220. Repealed. Sec. 13, Ch. 27, L. 2011.

History: En. 40-5808 by Sec. 8, Ch. 245, L. 1974; R.C.M. 1947, 40-5808(3) thru (6); amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 5, Ch. 576, L. 1987; amd. Sec. 13, Ch. 195, L. 2003.

33-10-221. Nomination of liquidator by association — notification given by liquidator. (1) The association may recommend an individual to serve as a special deputy to act for the commissioner and under the commissioner's supervision in the liquidation, rehabilitation, or supervision of any member insurer.

(2) The liquidator, rehabilitator, or supervisor of any impaired or insolvent insurer may notify all interested persons of the effect of this part.

History: En. 40-5811, 40-5813 by Secs. 11, 13, Ch. 245, L. 1974; R.C.M. 1947, 40-5811(4), 40-5813; amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 14, Ch. 195, L. 2003.

33-10-222. Stay of proceedings — reopening default judgments. (1) All proceedings in which the insolvent insurer is a party in any court in this state must be stayed 180 days from the date an order of liquidation, rehabilitation, or supervision is final to permit proper legal action by the association on any matters germane to its powers or duties.

(2) As to a judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and must be permitted to defend against the suit on the merits.

History: **En. 40-5819 by Sec. 19, Ch. 245, L. 1974; R.C.M. 1947, 40-5819; amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 15, Ch. 195, L. 2003; amd. Sec. 7, Ch. 27, L. 2011.**

Cross-References

Orders of rehabilitation, 33-2-1332.

Orders of liquidation, 33-2-1342.

33-10-223. Assignment by beneficiaries — subrogation. (1) Any person receiving benefits under this part must be considered to have assigned the person's rights under the covered policy or contract, pertaining to any causes of action against the person for losses resulting from or otherwise relating to the covered policy or contract, to the association to the extent of the benefits received because of this part whether the benefits are payments of contractual obligations or continuation of coverage or provision of substitute or alternative coverage. The association may require an assignment to it of the rights by any payee, policyowner or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this part upon the person. The association must be subrogated to these rights against the assets of any impaired or insolvent insurer.

(2) The subrogation rights of the association under this section have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this part.

(3) In addition to the rights detailed in this section, the association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contract, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this part, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for the annuity, except for any person responsible solely by reason of serving as an assignee with respect to a qualified assignment under section 130 of the Internal Revenue Code.

(4) If subsections (1) through (3) are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policy or a portion of the policy covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers any amount to which the association has rights as described in this section, the person shall pay to the association the portion of the recovery attributable to the policy or a portion of the policy covered by the association.

History: **En. 40-5808 by Sec. 8, Ch. 245, L. 1974; R.C.M. 1947, 40-5808(9); amd. Sec. 16, Ch. 195, L. 2003; amd. Sec. 8, Ch. 27, L. 2011.**

33-10-224. Coverage, limitations, and extent of liability. (1) (a) This part establishes coverage for the policies and contracts specified in subsection (2) to persons who, except as provided in subsections (1)(b) through (1)(e), are:

(i) beneficiaries, assignees, or payees, including health care providers, of the persons covered under subsection (1)(a)(ii) regardless of where the beneficiaries, assignees, or payees reside, except for nonresident certificate holders under group policies or contracts;

(ii) owners of or certificate holders or enrollees under the policies and contracts specified in subsection (2), other than unallocated annuity contracts and structured settlement annuities that are provided for in subsections (1)(b) and (1)(c), if the persons are:

(A) residents; or

(B) nonresidents, but only under all of the following conditions:

(I) the member insurer that issued the policies is domiciled in this state;

(II) the state in which the person resides has an association similar to the association created under this part; and

(III) the person is not eligible for coverage by an association in any other state because the insurer, health service corporation, or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(b) The provisions of subsection (1)(a) do not apply to unallocated annuity contracts specified in subsection (2). A person who is the owner of an unallocated annuity contract receives coverage under this part, except as provided in subsections (1)(d) and (1)(e), if:

(i) the contract is issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; or

(ii) the unallocated annuity contract was issued to or in connection with a government lottery if the owner is a resident.

(c) The provisions of subsection (1)(a) do not apply to structured settlement annuities specified in subsection (2). A person who is a payee under a structured settlement annuity or the beneficiary of a payee if the payee is deceased receives coverage under this part, except as provided in subsections (1)(d) and (1)(e), if the payee:

(i) is a resident, regardless of where the contract owner resides; or

(ii) is not a resident and one of the following conditions applies:

(A) the contract owner of the structured settlement annuity is a resident and is not eligible for coverage by another state's association, and the payee or beneficiary is not eligible for coverage by the association of the state in which the payee or beneficiary resides; or

(B) the contract owner of the structured settlement annuity is not a resident, the insurer that issued the structured settlement annuity is domiciled in this state, the state in which the contract owner resides has an association similar to the association created by this part, and the payee, beneficiary, and contract owner are not eligible for coverage by the association in the state in which the payee, beneficiary, or contract owner resides.

(d) This part does not provide coverage to:

(i) a person who is a payee or a beneficiary of a contract owner that is a resident of this state if the payee or beneficiary is afforded any coverage by the association of another state;

(ii) a person covered under subsection (1)(b) if any coverage is provided by the association of another state to the person; or

(iii) a person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(e) This part is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, a person may not receive coverage under this part if the person who would otherwise receive coverage under this part receives coverage under the laws of any other state. To determine the application of this subsection (1)(e) to a situation in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this part must be construed in conjunction with other state laws to result in coverage by only one association.

(2) (a) (i) Except as otherwise provided in this part, this part provides coverage to the persons specified in subsection (1) for:

(A) direct, nongroup life and health policies, direct, nongroup annuity contracts, and supplemental contracts to any of these;

(B) certificates under direct group policies and contracts and supplemental contracts to any of these; and

(C) unallocated annuity contracts issued by member insurers.

(ii) Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued in connection with government lotteries, and any immediate or deferred annuity contracts.

(b) This part does not provide coverage for any of the following:

(i) a portion of a policy or contract not guaranteed by the member insurer or under which the risk is borne by the policy or contract owner;

(ii) a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) except for the portion of the policy, including a rider, that provides long-term care or any other health insurance benefits, a portion of a policy or contract to the extent that the rate of interest on which the portion is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(A) when averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this part exceeds the rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average that is averaged for that same period or for a lesser period if the policy or contract was issued less than 4 years before the member insurer became an impaired or insolvent insurer under this part; and

(B) when the returns or changes in value exceed the rate of interest determined by subtracting 3 percentage points from the Moody's corporate bond yield average most recently available on or after the date on which the member insurer becomes an impaired or insolvent insurer under this part;

(iv) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. 1002;

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services-only contract;

(v) a portion of a policy or contract to the extent that it contains provisions for dividends, experience rating credits, or voting rights or for payment of any fees or allowances to any person, including the policyowner or contract owner, in connection with the service to or administration of the policy or contract;

(vi) a policy or contract issued in this state by a member insurer at any time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) any unallocated annuity contract issued to or in connection with a benefit plan that is protected under the federal pension benefit guaranty corporation, regardless of whether the federal pension benefit guaranty corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) a portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons' benefit plan or a government lottery;

(ix) a portion of a policy or contract to the extent that federal or state law preempts or otherwise does not permit the assessments required by 33-10-227 with respect to the policy or contract;

(x) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policyowner, including without limitation:

(A) claims based on marketing materials;

(B) claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable requirements for filing policy forms or for policy approval;

(C) misrepresentation of or regarding policy benefits;

(D) extracontractual claims; or

(E) a claim for penalties or consequential or incidental damages;

(xi) a contractual agreement that establishes the member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case may not be an affiliate of the member insurer;

(xii) a portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policyowner's or contract owner's rights are subject to forfeiture as of the date the member insurer becomes an impaired or insolvent insurer under this part. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this section, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of the impairment or insolvency of the member insurer and the interest or changes in value are not subject to forfeiture.

(xiii) a policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to either 42 U.S.C. 1395w-21 through 1395w-152, commonly known as medicare parts C and D, or 42 U.S.C. 1396 to 1396w-5, commonly known as medicaid, or any regulations issued pursuant to those federal statutes; or

(xiv) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(3) The benefits for which the association may become liable may not exceed the lesser of:

(a) the contractual obligations for which the insurer is liable or would have become liable if it were not an impaired or insolvent insurer; or

(b) (i) with respect to any one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(B) in health insurance benefits:

(I) $500,000 for health insurance coverage;

(II) $300,000 for disability income insurance;

(III) $300,000 for long-term care insurance;

(IV) $100,000, including any net cash surrender and net cash withdrawal values, for coverages not included in subsections (3)(b)(i)(B)(I) through (3)(b)(i)(B)(III);

(C) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code and covered by an unallocated annuity contract or with respect to the beneficiaries of each individual, if deceased, in the aggregate, $250,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) with respect to each payee of a structured settlement annuity or beneficiary of the payee if the payee is deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iv) with respect to either one contract owner provided coverage under subsection (1)(b) or one plan sponsor whose plan owns directly or in trust one or more unallocated annuity contracts not included in subsection (3)(b)(ii), $5 million in benefits, irrespective of the number of contracts held by the contract owner or plan sponsor. If one or more unallocated annuity contracts are covered contracts under this part and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage must be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state. In no event is the association obligated to cover more than $5 million in benefits with respect to all these unallocated contracts.

(4) In no event is the association obligated to cover more than:

(a) an aggregate of $300,000 in benefits with respect to any one life under subsections (3)(b)(i) through (3)(b)(iii), except with respect to benefits for health insurance coverage under subsection (3)(b)(i), in which case the aggregate liability of the association may not exceed $500,000 with respect to any one individual; and

(b) with respect to one owner of multiple nongroup policies of life insurance, whether the policyowner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, $5 million in benefits, regardless of the number of policies and contracts held by the owner.

(5) The limitations set forth in this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(6) In performing its obligations to provide coverage under this part, the association is not required to guarantee, assume, reinsure, or perform or cause to be guaranteed, assumed, reinsured, or performed the contractual obligations of the impaired or insolvent insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

(7) For purposes of this part, benefits provided by a long-term care rider to a life insurance policy or annuity contract must be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

History: **En. 40-5808 by Sec. 8, Ch. 245, L. 1974; R.C.M. 1947, 40-5808(10); amd. Sec. 6, Ch. 576, L. 1987; amd. Sec. 62, Ch. 596, L. 1993; amd. Sec. 17, Ch. 195, L. 2003; amd. Sec. 9, Ch. 27, L. 2011; amd. Sec. 6, Ch. 25, L. 2019.**

33-10-225. Association as creditor — use of assets. (1) For the purpose of carrying out its obligations under this part, the association is a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to 33-10-223.

(2) All assets of the impaired or insolvent insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this part. Assets attributable to covered policies, as used in this section, is that proportion of the assets which the reserves that should have been established for such policies bear to the reserve that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(3) As a creditor of the impaired or insolvent insurer, as established in this part and consistent with 33-2-1363, the association and other similar associations are entitled to receive a disbursement of assets out of the marshalled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this part. If, within 120 days of the receivership court issuing a final determination of insolvency of an insurer, the liquidator has not made an application to the court for the approval of a proposal to disburse assets out of marshalled assets to guaranty associations having obligations because of the insolvency, then the association may make application to the receivership court for approval of its own proposal to disburse those assets.

History: **En. 40-5814 by Sec. 14, Ch. 245, L. 1974; R.C.M. 1947, 40-5814(3); amd. Sec. 10, Ch. 27, L. 2011.**

Cross-References

Assets from liquidation, 33-2-1363.

33-10-226. Distribution of ownership rights — distribution to shareholders. (1) Prior to the termination of any liquidation, rehabilitation, or supervision proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policyowners of the impaired or insolvent insurer and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the impaired or insolvent insurer. In the determination, consideration must be given to the welfare of the policyowners of the continuing or successor insurer.

(2) A distribution to stockholders, if any, of an impaired or insolvent insurer may not be made until and unless the association has fully recovered the total amount of valid claims of the association, with interest, for funds expended in carrying out its powers and duties under this part.

History: **En. 40-5814 by Sec. 14, Ch. 245, L. 1974; R.C.M. 1947, 40-5814(4); amd. Sec. 140, Ch. 575, L. 1981; amd. Sec. 18, Ch. 195, L. 2003; amd. Sec. 11, Ch. 27, L. 2011.**

Cross-References

Assets from liquidation, 33-2-1363.

33-10-227. Assessments — abatement — basis for ratesetting. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at the times and for the amounts as the board finds necessary.

(2) Assessments are due not less than 30 days after prior written notice to the member insurers. An unpaid assessment accrues interest at 10% a year on and after the due date. The association may also impose any charges on a late-paid assessment if the plan of operation provides for late-paid assessments.

(3) There are two classes of assessments:

(a) Class A assessments must be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments must be authorized and called to the extent necessary to carry out the powers and duties of the association under 33-10-205 with regard to an impaired or insolvent insurer.

(4) (a) The amount of any Class A assessment for each account must be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the amount be credited against future Class B assessments.

(b) The amount of any Class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard determined by the board in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer must be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to life and annuity member insurers.

(d) Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account or subaccount bear to the premiums received on business in this state by all assessed member insurers. This ratio must be calculated from information that is available for the 3 most recent calendar years preceding the year in which the insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the 3 most recent calendar years for which information is available preceding the year in which the insurer became impaired.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized and called until necessary to implement the purposes of this part. Classification of assessments under subsection (3) and computation of assessments under this subsection (4) must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(5) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(6) (a) (i) Subject to the provisions of subsection (6)(a)(ii), the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account may not in 1 calendar year exceed

2% of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the 3 calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(ii) If two or more assessments are authorized in 1 calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subsection (6)(a)(i) must be equal and limited to the higher of the 3-year average annual premiums for the applicable account or subaccount as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in 1 year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon as permitted by this part.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, for use when the board determines that the maximum assessment is insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life insurance and annuity account in 1 year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (4)(d), the board shall assess the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum assessment stated in subsection (6)(a).

(7) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, and net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(8) It is proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(9) The association shall issue to each insurer paying an assessment under this part a certificate of contribution, in a form prescribed by the commissioner, for the amount paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in that form and for the amount, if any, and period of time that the commissioner may approve.

(10) (a) A member insurer that wishes to protest all or a part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment must be available to meet association obligations during the pendency of the protest or any subsequent appeal. A written statement must accompany the payment and must indicate that the payment is made under protest and include a brief description of the grounds for the protest.

(b) Within 60 days after the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issue raised by the protest.

(c) Within 30 days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) Instead of rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal of the assessment is upheld, the amount paid in error or excess must be returned to the member insurer. Interest on a refund due to a protesting member insurer must be paid at the rate actually earned by the association.

(11) The association may request information of member insurers to aid in the exercise of its powers and duties under this section. Member insurers shall promptly comply with a request from the association.

History: En. 40-5809 by Sec. 9, Ch. 245, L. 1974; R.C.M. 1947, 40-5809; amd. Sec. 7, Ch. 576, L. 1987; amd. Sec. 69, Ch. 596, L. 1993; amd. Sec. 19, Ch. 195, L. 2003; amd. Sec. 12, Ch. 27, L. 2011; amd. Sec. 7, Ch. 25, L. 2019.

33-10-228. Repealed. Sec. 13, Ch. 27, L. 2011.

History: En. 40-5811 by Sec. 11, Ch. 245, L. 1974; R.C.M. 1947, 40-5811(2), (3).

33-10-229. Repealed. Sec. 71, Ch. 596, L. 1993.

History: En. 40-5814 by Sec. 14, Ch. 245, L. 1974; R.C.M. 1947, 40-5814(6); amd. Sec. 18, Ch. 198, L. 1979.

33-10-230. Tax — writeoffs of certificates of contribution. (1) Unless a longer period has been allowed by the commissioner, a member insurer shall at its option have the right to show a certificate of contribution for a Class B assessment only as an asset in the form approved by the commissioner pursuant to 33-10-227(9), at percentages of the original face amount approved by the commissioner, for calendar years as follows:

(a) 100% for calendar year of issuance;
(b) 80% for the first calendar year after year of issuance;
(c) 60% for second calendar year after year of issuance;
(d) 40% for third calendar year after year of issuance;
(e) 20% for fourth calendar year after year of issuance.

(2) The insurer may offset the amount written off by it in the calendar year under subsection (1) above against its premium tax liability to this state accrued with respect to business transacted in the calendar year.

(3) Any sums acquired by refund, pursuant to 33-10-227(7), from the association which have therefore been written off by contributing insurers and offset against premium taxes as provided in subsection (2) above and are not then needed for purposes of this part must be paid by the association to the commissioner and deposited by the commissioner with the state treasurer for credit to the general fund of this state.

History: En. 40-5817 by Sec. 17, Ch. 245, L. 1974; R.C.M. 1947, 40-5817; amd. Sec. 8, Ch. 576, L. 1987; amd. Sec. 70, Ch. 596, L. 1993.

Cross-References

Tax on premiums, 33-2-705.

33-10-231 through 33-10-234 reserved.

33-10-235. Association election to continue reinsurance. (1) Within 1 year after the coverage date, which is the date that the association becomes responsible for the obligations of a member insurer, the association may elect to succeed to the rights and obligations of a member insurer that accrued on or after the coverage date under an indemnity reinsurance agreement entered into by the member insurer as the ceding insurer. The association may not exercise an election with respect to a reinsurance agreement if the rehabilitator or liquidator of the member insurer has previously expressly disaffirmed the agreement.

(2) The election to succeed to the rights and obligations of the member insurer must be accomplished through notice to the supervisor, rehabilitator, or liquidator and to the affected reinsurers.

(3) If the association makes an election, the association:

(a) is responsible for all unpaid premiums due under the agreements for the periods before and after the coverage date and is responsible for the performance of all obligations to be performed after the coverage date in each contract covered, either in whole or in part, by the association. The association may charge contracts covered in part by the association the costs for reinsurance in excess of the obligations of the association, using reasonable allocation methods.

(b) is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association, in whole or in part. In order to receive these amounts, the association must be obligated to pay the beneficiary of the underlying policy or contract a portion of the amount equal to the excess of the amount received by the association minus:

(i) the benefits paid by the association under the policy or contract; and
(ii) any amount properly retained by the impaired or insolvent insurer for the loss or event.

(c) shall calculate, within 30 days of the election, the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid to either the member insurer, its rehabilitator or liquidator, or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or the indemnity insurer shall pay the net balance due the other within 5 days of completion of the calculation. If the rehabilitator or liquidator has received any amount under this section, the rehabilitator or liquidator shall remit it to the association as soon as practicable.

(4) If, within 60 days of the election, the association pays the premiums due for the periods before and after the coverage date that relate to the contracts covered by the association, either in whole or in part, the reinsurer may not terminate the reinsurance agreement insofar as the agreement relates to contracts covered by the association, in whole or in part, and is not entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association.

(5) The association may transfer any rights or obligations under this section to a third-party insurer under terms agreed upon by the association and the third-party insurer.

(6) Except as otherwise expressly stated in this section, this section may not be construed to alter or modify the terms and conditions of the reinsurance agreement of an insolvent member insurer. This section is not intended to:

(a) abrogate or limit any rights of a reinsurer to claim that it is entitled to rescind a reinsurance agreement; or

(b) give a policyowner or beneficiary an independent cause of action against an insurer that is not otherwise provided for in the reinsurance agreement.

History: En. Sec. 1, Ch. 195, L. 2003.

33-10-236. Deposits paid to association. (1) A deposit in this state that is held pursuant to law or required by the commissioner to be held for the benefit of creditors, including policyowners, and that is not turned over to the liquidator upon entry of the final order of liquidation or upon entry of the order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state pursuant to 33-2-1381 must be promptly paid to the association.

(2) The association is entitled to retain a portion of any amount paid under this section equal to the percentage determined by dividing the aggregate amount of policyowner claims related to the insolvency for which the association has provided statutory benefits by the aggregate amount of all policyowner claims in this state related to the insolvency. The association shall remit to the domiciliary receiver the amount paid to the association and not retained under this section.

History: En. Sec. 2, Ch. 195, L. 2003.

CHAPTER 11
LIABILITY RISK RETENTION AND PURCHASING GROUPS

Part 1 — General Provisions

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Part 1
General Provisions

33-11-101. Purpose. The purpose of this part is to regulate the formation and operation of risk retention groups and purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 (15 U.S.C. 3901, et seq.).

History: **En. Sec. 1, Ch. 249, L. 1987.**

33-11-102. Definitions. As used in this part, the following definitions apply:

(1) "Completed operations liability" means:

(a) liability arising out of the installation, maintenance, or repair of any product at a site that is not owned or controlled by:

(i) a person who performs that work; or

(ii) a person who hires an independent contractor to perform that work; and

(b) liability for activities that are completed or abandoned before the date of the occurrence giving rise to the liability.

(2) "Domicile", for purposes of determining the state where a purchasing group is domiciled, means:

(a) for a corporation, the state where the purchasing group is incorporated; and

(b) for an unincorporated entity, the state of its principal place of business.

(3) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able to:

(a) meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(b) pay other obligations in the normal course of business.

(4) "Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance, and any other arrangement for shifting and distributing risk that is determined to be insurance under the laws of this state.

(5) (a) "Liability" means legal liability for damages, including costs of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to other persons resulting from or arising out of:

(i) a business, whether profit or nonprofit, trade, product, service (including professional service), premises, or operation; or

(ii) an activity of any state or local government or an agency or political subdivision of state or local government.

(b) The term does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the federal Employers' Liability Act, 45 U.S.C. 51 through 60. As used in this subsection, "personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from personal, familial, or household responsibilities or activities rather than from responsibilities or activities referred to in subsection (5)(a).

(6) "Plan of operation or a feasibility study" means an analysis that presents the expected activities and results of a risk retention group, including at a minimum:

(a) the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer;

(b) historical and expected loss experience of the proposed members and national experience of similar exposures to the extent this experience is reasonably available;

(c) pro forma financial statements and projections;

(d) appropriate opinions by a qualified independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(e) identification of management, underwriting procedures, managerial oversight methods, and investment policies; and

(f) other matters as may be prescribed by the commissioner for liability insurance companies authorized by the insurance laws of the state where the risk retention group is chartered.

(7) "Purchasing group" means a group that:

(a) has as one of its purposes the purchase of liability insurance on a group basis;

(b) purchases liability insurance only for its group members and only to cover their similar or related liability exposure, as described in subsection (7)(c);

(c) is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, service, premises, or operation; and

(d) is domiciled in any state.

(8) "Risk retention group" means a corporation or other limited liability association formed under the laws of any state, Bermuda, or the Cayman Islands:

(a) whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;

(b) that is organized for the primary purpose of conducting the activity described under subsection (8)(a);

(c) (i) that is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

(ii) that, before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the insurance regulatory official of at least one state that it satisfied the capitalization requirements of that state. However, the group is considered to be a risk retention group only if it has been engaged in business continuously since January 1, 1985, and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability. For purposes of this subsection (8), "product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage, or property damage, including damages resulting from the loss of use of property, arising out of the manufacture, design, importation, distribution, packaging, labeling, lease, or sale of a product but does not include the liability of any person for those damages if the product involved was in the possession of that person when the incident giving rise to the claim occurred.

(d) that does not exclude any person from membership in the group solely to provide to members of the group a competitive advantage over the person;

(e) (i) that has as its members only persons who have an ownership interest in the group and that has as its owners only persons who are members and who are provided insurance by the risk retention group; or

(ii) that has as its sole member and sole owner an organization that is owned by persons who are provided insurance by the risk retention group;

(f) whose members are engaged in businesses or activities that are similar or related with respect to the liability to which the members are exposed by virtue of any related, similar, or common business, trade, product, service, premises, or operation;

(g) whose activities do not include the provision of insurance other than:

(i) liability insurance for assuming and spreading all or any portion of the liability of its group members; and

(ii) reinsurance with respect to the liability of any other risk retention group or member of the other group that is engaged in businesses or activities so that the group or member meets the requirement described in subsection (8)(f) for membership in the risk retention group that provides the reinsurance; and

(h) whose name includes the phrase "risk retention group".

(9) "State" means any state of the United States or the District of Columbia.

History: En. Sec. 2, Ch. 249, L. 1987; amd. Sec. 41, Ch. 379, L. 1995.

33-11-103. Chartering — licensing — plan of operation. (1) A risk retention group seeking to be chartered in this state must be chartered and licensed to write only casualty insurance pursuant to the insurance laws of this state and, except as provided in this part, shall comply with all of the laws, rules, regulations, and requirements applicable to the insurers chartered and authorized in this state, including 33-11-104, to the extent that the requirements are not a limitation on laws, rules, regulations, or requirements of this state. Before offering insurance in any state, the risk retention group shall also submit for approval to the commissioner a plan of operation or a feasibility study and revisions of the plan or study if the group intends to offer any additional lines of liability insurance.

(2) At the time of filing its application for charter, the risk retention group shall provide to the commissioner in summary form the following information:

(a) the identity of the initial members of the risk retention group;

(b) the identity of those individuals who organized the risk retention group or who will provide administrative services or otherwise influence or control the activities of the risk retention group;

(c) the amount and nature of initial capitalization;

(d) the coverages to be afforded; and

(e) the states in which the risk retention group intends to operate.

(3) Upon receipt of the information required under subsection (2), the commissioner shall forward the information to the national association of insurance commissioners. Providing this information to the national association of insurance commissioners does not satisfy the requirements of 33-11-104 or any other section of this chapter.

(4) All risk retention groups chartered in this state shall file with the department and the national association of insurance commissioners an annual statement in a form prescribed by the national association of insurance commissioners, including electronically if required by the commissioner, and completed in accordance with instructions provided by the national association of insurance commissioners and the national association of insurance commissioners' accounting practices and procedures manual.

(5) All risk retention groups must be in compliance with the governance standards contained within this section within 1 year of April 30, 2015. New risk retention groups must be in compliance with the standards at the time of licensure.

(6) (a) The board of directors of the risk retention group must consist of a majority of independent directors. If the risk retention group is reciprocal, the attorney-in-fact shall adhere to the same standards regarding independence of operation and governance as are imposed on the risk retention group's board of directors under these standards. The board of directors shall affirmatively determine that a director has no material relationship with the risk retention group for that director to be considered independent.

(b) Each risk retention group shall disclose the determinations of independence to the commissioner annually.

(c) (i) For the purpose of determining independence under this subsection (6), any person that is a direct or indirect owner of or a subscriber in the risk retention group or is an officer, director, or employee of the owner and insured, unless meeting the material relationship provisions under subsection (6)(c)(ii), is considered to be independent.

(ii) A person described in subsection (6)(c)(i) is not considered independent and has a material relationship of its members, as described in 15 U.S.C. 3901(a)(4)(E)(ii), if the person, a member of the person's immediate family, or any business with which the person is affiliated:

(A) has received in any 12-month period from the risk retention group, including a consultant or a service provider to the risk retention group, compensation or payment of any item of value that accounts for either 5% of the risk retention group's gross written premium for that 12-month period or 2% of the risk retention group's surplus, whichever is greater;

(B) has a relationship of employment or affiliation in a professional capacity or has had a relationship of employment or affiliation within 1 year with a present or former internal or external auditor of the risk retention group; or

(C) has a relationship or has had a relationship within 1 year with a related entity by which a director or an immediate family member of the director is employed as an executive officer. This condition includes any of the risk retention group's present executives serving on the related company's board of directors.

(7) (a) A material service provider contract with a risk retention group or its renewal:

(i) may not exceed 5 years;

(ii) requires the approval of a majority of the risk retention group's independent directors; and

(iii) is considered material if the amount to be paid for the contract is greater than or equal to 5% of the risk retention group's annual gross written premium or 2% of the risk retention group's surplus, whichever is greater.

(b) The entire board of directors may terminate any service provider contract at any time for cause after providing adequate notice as defined in the contract.

(c) The board may not enter a service provider contract with a person who has a material relationship with the risk retention group as provided in subsection (6)(c)(ii) unless the board has notified the commissioner at least 30 days prior to entering the contract and the commissioner has not disapproved the contract.

(8) The risk retention group's board of directors shall adopt in the plan of operation a written policy that requires the board to:

(a) ensure that all owners or insureds of the risk retention group receive evidence of ownership interest;

(b) develop a set of governance standards applicable to the risk retention group;

(c) oversee the evaluation of the risk retention group's management, including but not limited to the performance of the captive manager, managing general underwriter, or any other party that is responsible for underwriting, determination of rates, collection of premium, adjusting or settling claims, or the preparation of financial statements;

(d) review and approve the amount to be paid for all material service providers; and

(e) review and approve at least annually:

(i) the risk retention group's goals and objectives relevant to the compensation of officers and service providers;

(ii) the officers' and service providers' performance in light of those goals and objectives; and

(iii) the continued engagement of the officers and material service providers.

(9) (a) Except as provided in subsection (9)(b), the risk retention group shall name an audit committee composed of at least three independent board members as defined in subsection (6)(c)(i). A nonindependent board member may participate in the activities of the audit committee but may not be a member of the audit committee.

(b) The entire board of directors shall serve as the audit committee if the board chooses not to designate a separate audit committee.

(10) An audit committee shall approve a written charter that defines the committee's purpose, which at a minimum must be to:

(a) assist board oversight of:

(i) the integrity of the financial statements;

(ii) the board's compliance with legal and regulatory requirements; and

(iii) the qualifications, independence, and performance of the independent auditor and actuary;

(b) discuss the annual audited financial statements and quarterly financial statements with management;

(c) discuss the annual audited financial statement with its independent auditor and, if advisable, discuss its quarterly financial statements with its independent auditor;

(d) discuss policies with respect to risk assessment and risk management;

(e) meet separately and periodically, either directly or through a designated representative of the committee, with management and independent auditors;

(f) review with the independent auditor any audit problems or difficulties and management's response;

(g) set clear hiring policies of the risk retention group as to the hiring of employees or former employees of the independent auditor;

(h) require the external auditor to rotate the lead or coordinating audit partner having primary responsibility for the risk retention group's audit as well as the audit partner responsible for reviewing the audit so that neither individual performs audit services for more than 5 consecutive fiscal years; and

(i) report regularly to the board of directors.

(11) (a) The board of directors shall adopt and disclose standards that make information available through electronic or other means and shall provide that information upon request.

(b) For the purposes of this subsection (11), the information must include:

(i) the process by which the directors are elected by the owner or the insureds;

(ii) qualification standards, responsibilities, and compensation for directors;

(iii) director access to management and, as necessary and appropriate, to independent advisors;

(iv) director orientation and continuing education;

(v) management succession policies and procedures; and

(vi) annual board performance evaluation policies and procedures.

(12) (a) The board of directors shall adopt and disclose a code of business conduct and ethics for directors, officers, and employees. Any waivers of this code as the code applies to directors and officers must be voted on by a majority of the independent directors.

(b) The code must address:

(i) conflicts of interest, including director's conflicting interest transactions as defined in 35-14-860;

(ii) confidentiality;

(iii) fair dealing;

(iv) protection and proper use of risk retention group assets;

(v) compliance with all applicable laws, rules, and regulations; and

(vi) requirements for the reporting of any illegal or unethical behavior that affects the operation of the risk retention group.

(13) The captive manager, president, or chief executive officer of the risk retention group shall promptly notify the commissioners in writing as soon as that person is aware of any material noncompliance with any standard provided for in this section.

History: En. Sec. 3, Ch. 249, L. 1987; amd. Sec. 63, Ch. 596, L. 1993; amd. Sec. 36, Ch. 370, L. 2015; amd. Sec. 236, Ch. 271, L. 2019.

33-11-104. Risk retention groups not chartered in this state. A risk retention group chartered in a state other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state as follows:

(1) Before offering insurance in this state, a risk retention group shall submit to the commissioner:

(a) a statement identifying the state or states where the risk retention group is chartered and authorized as a casualty insurer, date of chartering, its principal place of business, and other information, including information on its membership, as the commissioner requires to verify that the risk retention group is qualified under 33-11-102(8);

(b) a copy of its plan of operation or a feasibility study and revisions of the plan or study submitted to its state of domicile. However, this provision relating to the submission of a plan of operation or a feasibility study does not apply with respect to any line or classification of liability insurance that was defined in the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by Public Law 99-563, approved on October 27, 1986, and that was offered before that date by a risk retention group that had been chartered and operated for not less than 3 years before that date; and

(c) a statement of registration that designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(2) A risk retention group doing business in this state shall submit to the commissioner:

(a) a copy of the group's financial statement submitted to its state of domicile, which must be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American academy of actuaries or by a qualified loss reserve specialist under criteria established by the national association of insurance commissioners;

(b) a copy of each examination of the risk retention group as certified by the insurance regulatory official of the state in which the examination was conducted or public official conducting the examination;

(c) upon request by the commissioner, a copy of any audit performed with respect to the risk retention group; and

(d) any information as may be required to verify the group's continuing qualification as a risk retention group under 33-11-102(8).

(3) (a) Each risk retention group is liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this state and shall report to the commissioner the net premiums written for risks resident or located within this state. The risk retention group is subject to taxation and any applicable interest, fines, and penalties for nonpayment that apply to foreign admitted insurers.

(b) To the extent that an insurance producer is used, the insurance producer shall report to the commissioner the premiums of direct business for risks resident or located within this state that the licensees have placed with or on behalf of a risk retention group not chartered in this state.

(c) To the extent that an insurance producer is used, the insurance producer shall keep a complete and separate record of all policies procured from each risk retention group. The record is open to examination by the commissioner, as provided in 33-1-408. The records must, for each policy and each kind of insurance provided under the policy, include the limit of liability, the time period covered, the effective date, the name of the risk retention group that issued the policy, the gross premium charged, and the amount of return premiums, if any.

(4) Each risk retention group, its insurance producers, and its representatives shall comply with Title 33, chapter 18, part 2.

(5) Each risk retention group shall comply with the provisions of Title 33, chapter 18, part 2, regarding deceptive, false, or fraudulent acts or practices. However, if the commissioner seeks an injunction regarding the risk retention group's conduct, the injunction must be obtained from a court of competent jurisdiction.

(6) Each risk retention group shall submit to an examination by the commissioner to determine its financial condition if the insurance regulatory official of the jurisdiction where the group is chartered has not initiated an examination or does not initiate an examination within 60 days after a request by the commissioner. The examination must be coordinated to avoid unjustified repetition and be conducted in an expeditious manner in accordance with the national association of insurance commissioners examiners handbook.

(7) Each policy issued by a risk retention group must contain, in 10-point type on the front page and the declaration page, the following notice:

"NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group."

(8) The following acts by a risk retention group are prohibited:

(a) the solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in the group; and

(b) the solicitation or sale of insurance by or operation of a risk retention group that is in a hazardous financial condition or is financially impaired.

(9) A risk retention group is not allowed to do business in this state if an insurer is directly or indirectly a member or owner of the risk retention group, other than in the case of a risk retention group all of whose members are insurers.

(10) A risk retention group may not offer insurance policy coverage declared unlawful by the Montana supreme court.

(11) A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by the insurance regulatory official of any state if there has been a finding of financial impairment after an examination under subsection (6).

(12) Upon completion of registration requirements, the commissioner shall issue to the risk retention group a proper certificate of registration.

(13) A risk retention group that violates any provision of this chapter is subject to fines and penalties, including revocation of the right to do business in this state, applicable to licensed insurers generally.

History: **En. Sec. 4, Ch. 249, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 14, Ch. 451, L. 1993; amd. Sec. 64, Ch. 596, L. 1993; amd. Sec. 42, Ch. 379, L. 1995.**

33-11-105. Compulsory associations. (1) A risk retention group may not join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state. In addition, a risk retention group or its insureds may not receive any benefit from any guaranty fund for claims arising out of the operations of the risk retention group.

(2) A risk retention group shall participate in this state's joint underwriting associations, mandatory liability pools, and similar mechanisms.

(3) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or from a risk retention group, the risks, wherever resident or located, may not be covered by any insurance guaranty fund or similar mechanism in this state.

(4) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state may be covered by the state guaranty fund, subject to Title 33, chapter 10, part 1.

History: En. Sec. 5, Ch. 249, L. 1987; amd. Sec. 56, Ch. 10, L. 1993; amd. Sec. 65, Ch. 596, L. 1993; amd. Sec. 21, Ch. 475, L. 2005; amd. Sec. 1, Ch. 21, L. 2021.

33-11-106. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 6, Ch. 249, L. 1987.

33-11-107. Purchasing groups — exemption from certain laws relating to group purchase of insurance. A purchasing group meeting the criteria established under the provisions of the federal Liability Risk Retention Act of 1986 (15 U.S.C. 3901, et seq.) is exempt from any law of this state relating to the formation of groups for the purchase of insurance, prohibition of group purchasing, or any law that would discriminate against a purchasing group or its members. In addition, an insurer is exempt from any law of this state that prohibits providing or offering to provide to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages, or other matters. A purchasing group is subject to all other applicable laws of this state.

History: En. Sec. 7, Ch. 249, L. 1987.

33-11-108. Notice and registration requirements of purchasing groups. (1) A purchasing group that intends to do business in this state shall furnish notice to the commissioner that:

(a) identifies the state where the group is domiciled and all other states in which the group intends to do business;

(b) specifies the lines and classifications of liability insurance that the purchasing group intends to purchase;

(c) identifies the insurer from which the purchasing group intends to purchase its insurance and the domicile of that insurer;

(d) identifies the Montana-licensed insurance producer or Montana-licensed surplus lines insurance producer through which the purchasing group intends to place its business;

(e) identifies the principal place of business of the purchasing group;

(f) provides information required by the commissioner to verify that the purchasing group is qualified under 33-11-102(7); and

(g) identifies the person or persons controlling the activities of the group and includes biographical information on the person or persons.

(2) The purchasing group shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process. However, the requirements do not apply in the case of a purchasing group:

(a) (i) that was domiciled before April 2, 1986, in any state of the United States; and

(ii) that was domiciled on and after October 27, 1986, in any state of the United States;

(b) (i) that, before October 27, 1986, purchased insurance from an insurer licensed in any state; and

(ii) that, since October 27, 1986, purchased its insurance from an insurer licensed in any state;

(c) that was a purchasing group under the requirements of the federal Product Liability Risk Retention Act of 1981 (15 U.S.C. 3901 through 3904) before it was amended by Public Law 99-563, approved on October 27, 1986; and

(d) that does not purchase insurance that was not authorized for purposes of an exemption under the federal Product Liability Risk Retention Act of 1981, as in effect before October 27, 1986.

(3) Upon completion of registration requirements, the commissioner shall issue a proper certificate of registration to the purchasing group.

History: **En. Sec. 8, Ch. 249, L. 1987; amd. Sec. 3, Ch. 180, L. 1991; amd. Sec. 15, Ch. 451, L. 1993; amd. Sec. 66, Ch. 596, L. 1993; amd. Sec. 43, Ch. 379, L. 1995.**

33-11-109. Restriction on insurance purchased by purchasing groups. (1) A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not authorized in the state where the purchasing group is located, unless the purchase is effected through a licensed insurance producer acting pursuant to the surplus lines laws and regulations of that state.

(2) For purposes of subsection (1), the state where a purchasing group is located is each state where a member of the purchasing group has a risk resident, located, or to be performed.

(3) A purchasing group that obtains liability insurance from an insurer not admitted in this state or from a risk retention group shall inform each of the members of the group who have a risk resident or located in this state that the risk is not protected by an insurance insolvency guaranty fund in this state and that the insurer or risk retention group may not be subject to all insurance laws and regulations of this state.

(4) A purchasing group may not purchase insurance that provides for a deductible or self-insured retention applicable to the group as a whole. Coverage may provide for a deductible or self-insured retention applicable to individual members.

(5) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits that are applicable to all purchases of group insurance.

History: **En. Sec. 9, Ch. 249, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 67, Ch. 596, L. 1993.**

33-11-110. Taxation of purchasing group. Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing group must be:

(1) imposed at the same rate and subject to the same interest, fines, and penalties as those applicable to premium taxes and taxes on premiums paid to surplus lines insurers and authorized insurers, pursuant to 33-2-311 and 33-2-705, respectively; and

(2) paid by the authorized or surplus lines insurers and, if not paid by them, paid by the insurance producer for the purchasing group and, if not paid by the insurance producer, paid by the purchasing group and, if not paid by the purchasing group, paid by each of its members.

History: **En. Sec. 34, Ch. 596, L. 1993.**

33-11-111 through 33-11-120 reserved.

33-11-121. Administrative and procedural authority regarding risk retention groups and purchasing groups. The commissioner is authorized to use any powers established under this title to enforce the laws of this state so long as those powers are not specifically preempted by the federal Liability Risk Retention Act of 1986 (15 U.S.C. 3901, et seq.). The commissioner's powers include but are not limited to the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders, and impose penalties. With regard to any investigation, administrative proceedings, or litigation, the commissioner may rely on the procedural law and regulations of the state. The injunctive authority of the commissioner in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

History: **En. Sec. 10, Ch. 249, L. 1987.**

33-11-122. Penalties. A risk retention group that violates any provision of this part is subject to fines and penalties applicable to licensed insurers generally, including revocation of its license to do business in this state.

History: **En. Sec. 11, Ch. 249, L. 1987.**

33-11-123. Duty of insurance producers to obtain license. A person acting or offering to act as an insurance producer for a risk retention group or purchasing group that solicits members, sells insurance coverage, purchases coverage for its members located within the state, or otherwise does business in this state shall, before commencing such activity, obtain a license from the commissioner.

History: En. Sec. 12, Ch. 249, L. 1987; amd. Sec. 1, Ch. 713, L. 1989.

33-11-124. Enforceability of orders issued in United States district court. An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state, territory, or possession of the United States upon a finding that such a group is in a hazardous financial condition is enforceable in the courts of this state.

History: En. Sec. 13, Ch. 249, L. 1987.

33-11-125. Rules and regulations. The commissioner may make and amend any reasonable rules relating to risk retention groups and purchasing groups necessary or desirable to carry out the provisions of this part.

History: En. Sec. 14, Ch. 249, L. 1987.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

CHAPTER 12
INSURER INVESTMENTS

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Part 1
General Provisions

33-12-101. Purpose and scope. (1) The purpose of this chapter is to protect the interests of insureds by promoting insurer solvency and financial strength. This purpose will be accomplished through the application of investment standards that facilitate a reasonable balance of the following objectives:

(a) to preserve principal;

(b) to ensure reasonable diversification as to type of investment, issuer, and credit quality; and

(c) to allow insurers to allocate investments in a manner consistent with principles of prudent investment management to achieve an adequate return so that obligations to insureds are adequately met and financial strength is sufficient to cover reasonably foreseeable contingencies.

(2) This chapter applies only to investments and investment practices of domestic insurers and United States branches of alien insurers entered through this state. This chapter does not apply to separate accounts of an insurer.

History: En. Sec. 1, Ch. 304, L. 1999.

33-12-102. Definitions. As used in this chapter, the following definitions apply:

(1) "Acceptable collateral" means:

(a) (i) as to securities lending transactions and for the purpose of calculating the counterparty exposure amount, cash, cash equivalents, letters of credit, or direct obligations of or securities that are fully guaranteed as to principal and interest by the government of the United States, by any agency of the United States, by the federal national mortgage association, or by the federal home loan mortgage corporation; and

(ii) as to lending foreign securities, sovereign debt rated 1 by the SVO;

(b) as to repurchase transactions, cash, cash equivalents, and direct obligations of or securities that are fully guaranteed as to principal and interest by the government of the United States, by an agency of the United States, by the federal national mortgage association, or by the federal home loan mortgage corporation; and

(c) as to reverse repurchase transactions, cash and cash equivalents.

(2) "Acceptable private mortgage insurance" means insurance written by a private insurer protecting a mortgage lender against loss occasioned by a mortgage loan default and issued by a licensed mortgage insurance company, with an SVO 1 designation or a rating issued by a nationally recognized statistical rating organization equivalent to an SVO 1 designation, that covers losses up to an 80% loan-to-value ratio.

(3) "Accident and health insurance" means insurance protection that provides payment of benefits for covered sickness or accidental injury, excluding credit insurance, disability insurance, accidental death and dismemberment insurance, and long-term care insurance.

(4) "Accident and health insurer" means a licensed life or health insurer or health service corporation whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutorily required reserves.

(5) (a) "Admitted assets" means, subject to subsection (5)(b), assets determined in accordance with the requirements of 33-2-501.

(b) The term does not include assets of separate accounts. The investments of separate accounts are not subject to the provisions of this chapter.

(6) "Affiliate" has the meaning provided in 33-2-1101.

(7) (a) "Asset-backed security" means a security or other instrument, excluding a mutual fund, evidencing an interest in or the right to receive payments from or payable from distributions

on an asset, a pool of assets, or specifically divisible cash flows that are legally transferred to a trust or another special purpose bankruptcy-remote business entity, on the following conditions:

(i) the trust or other business entity is established solely for the purpose of acquiring specific types of assets or rights to cash flows, issuing securities and other instruments representing an interest in or right to receive cash flows from those assets or rights, and engaging in activities required to service the assets or rights and any credit enhancement or support features held by the trust or other business entity; and

(ii) the assets of the trust or other business entity consist solely of interest-bearing obligations or other contractual obligations representing the right to receive payment from the cash flows from the assets or rights.

(b) However, the existence of credit enhancements, such as letters of credit, guarantees, or support features, such as swap agreements, may not cause a security or other instrument to be ineligible as an asset-backed security.

(8) "Business entity" includes a sole proprietorship, corporation, limited liability company, association, partnership, joint-stock company, joint venture, mutual fund, trust, joint tenancy, or other similar form of business organization, whether organized for profit or not for profit.

(9) "Cap" means an agreement obligating the seller to make payments to the buyer, with each payment based on the amount by which a reference price or level or the performance or value of one or more underlying interests exceeds a predetermined number. The predetermined number is sometimes called the strike rate or strike price.

(10) "Capital and surplus" means the sum of the capital and surplus of the insurer required to be shown on the most recent statutory financial statement of the insurer required to be filed with the commissioner.

(11) "Cash equivalents" means short-term, highly rated, and highly liquid investments or securities readily convertible to known amounts of cash without penalty and so near maturity that they present insignificant risk of change in value. Cash equivalents include government money market mutual funds and class one money market mutual funds.

(12) "Class one bond mutual fund" means a mutual fund that at all times qualifies for investment using the bond class one reserve factor under the Purposes and Procedures of the Securities Valuation Office or any successor publication.

(13) "Class one money market mutual fund" means a money market mutual fund that at all times qualifies for investment using the bond class one reserve factor under the Purposes and Procedures of the Securities Valuation Office or any successor publication.

(14) "Collar" means an agreement to receive payments as the buyer of an option, cap, or floor and to make payments as the seller of a different option, cap, or floor.

(15) "Construction loan" means a loan for a term of less than 3 years that is made for financing the cost of construction of a building or other improvement to real estate and that is secured by the real estate.

(16) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract (other than a commercial contract for goods or nonmanagement services), or otherwise, unless the power is the result of an official position with a corporation or a corporate office held by the person. Presumption of control is pursuant to 33-12-108.

(17) "Counterparty exposure amount" means the net amount of credit risk attributable to a derivative instrument, pursuant to 33-12-109, entered into with a business entity other than through a qualified exchange or qualified foreign exchange or cleared through a qualified clearinghouse. The derivative instrument is also known as an over-the-counter derivative instrument.

(18) "Covered" means that an insurer:

(a) owns or can immediately acquire, through the exercise of options, warrants, or already-owned conversion rights, the underlying interest in order to fulfill or secure its obligations under a call option, cap, or floor it has written; or

(b) has set aside, under a custodial or escrow agreement, cash or cash equivalents with a market value equal to the amount required to fulfill its obligations under a put option it has written in an income generation transaction.

(19) "Credit tenant loan" means a mortgage loan that is made primarily in reliance on the credit standing of a major tenant, structured with an assignment of the rental payments to the lender with real estate pledged as collateral in the form of a first lien.

(20) (a) "Derivative instrument" means an agreement, an option, an instrument, or a series or combination of agreements, options, or instruments:

(i) to make or take delivery of or assume or relinquish a specified amount of one or more underlying interests or to make a cash settlement in lieu of delivery; or

(ii) that has a price, level, performance, value, or cash flow based primarily upon the actual or expected price, level, performance, value, or cash flow of one or more underlying interests.

(b) (i) Derivative instruments include options, warrants used in a hedging transaction and not attached to another financial instrument, caps, floors, collars, swaps, forwards, futures, and any other agreements, options, or instruments substantially similar to the enumerated instruments or any series or combination of the enumerated instruments and any agreements, options, or instruments permitted under rules adopted pursuant to 33-12-111.

(ii) Derivative instruments do not include an investment authorized by 33-12-203 through 33-12-209, 33-12-211, and 33-12-305 through 33-12-309.

(21) "Derivative transaction" means a transaction involving the use of one or more derivative instruments.

(22) "Direct" or "directly", when used in connection with an obligation, means that the designated obligor is primarily liable on the instrument representing the obligation.

(23) "Dollar roll transaction" means two simultaneous transactions with different settlement dates that are no more than 96 days apart, so that in the transaction with the earlier settlement date, an insurer sells to a business entity, and in the other transaction, the insurer is obligated to purchase from the same business entity, substantially similar securities of the following types:

(a) asset-backed securities issued, assumed, or guaranteed by the government national mortgage association, the federal national mortgage association, or the federal home loan mortgage corporation or their successors; and

(b) other asset-backed securities referred to in section 106 of Title I of the Secondary Mortgage Market Enhancement Act of 1984 (15 U.S.C. 77r-1), as amended.

(24) "Domestic jurisdiction" means the United States, any state, Canada, any province of Canada, or any political subdivision of a state or province.

(25) "Equity interest" means any of the following that are not rated credit instruments:

(a) common stock;

(b) preferred stock;

(c) trust certificate;

(d) equity investment in an investment company other than a money market mutual fund or a class one bond mutual fund;

(e) investment in a common trust fund of a bank regulated by a federal or state agency;

(f) an ownership interest in minerals, oil, or gas, the rights to which have been separated from the underlying fee interest in the real estate where the minerals, oil, or gas is located;

(g) instruments that are mandatorily, or at the option of the issuer, convertible to equity;

(h) limited partnership interests and those general partnership interests authorized under 33-12-104(4);

(i) member interests in limited liability companies;

(j) warrants or other rights to acquire equity interests that are created by the person that owns or would issue the equity to be acquired; or

(k) instruments that would be rated credit instruments except for the provisions of subsection (70)(b).

(26) "Equivalent securities" means:

(a) in a securities lending transaction, securities that are identical to the loaned securities in all features including the amount of the loaned securities, except as to certificate number if held in physical form, but if any different security is exchanged for a loaned security by recapitalization, merger, consolidation, or other corporate action, the different security is considered to be the loaned security;

(b) in a repurchase transaction, securities that are identical to the purchased securities in all features including the amount of the purchased securities, except as to the certificate number if held in physical form; or

(c) in a reverse repurchase transaction, securities that are identical to the sold securities in all features including the amount of the sold securities, except as to the certificate number if held in physical form.

(27) "Floor" means an agreement obligating the seller to make payments to the buyer in which each payment is based on the amount by which a predetermined number, sometimes called the floor rate or price, exceeds a price, level, performance, or value of one or more underlying interests.

(28) "Foreign currency" means a currency other than that of a domestic jurisdiction.

(29) (a) "Foreign investment" means an investment in a foreign jurisdiction, or an investment in a person, real estate, or asset domiciled in a foreign jurisdiction, that is substantially of the same type as those eligible for investment under part 2 of this chapter, 33-12-301 through 33-12-306, 33-12-308, 33-12-310 through 33-12-312, and this part.

(b) An investment may not be considered to be foreign if the issuing person, qualified primary credit source, or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(i) the issuing person is a shell business entity; and

(ii) the investment is not assumed, accepted, guaranteed or insured, or otherwise backed by a domestic jurisdiction or a person that is not a shell business entity and that is domiciled in a domestic jurisdiction.

(30) "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction.

(31) "Forward" means an agreement, other than a future, to make or take delivery of or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests.

(32) "Future" means an agreement, traded on a qualified exchange or qualified foreign exchange, to make or take delivery of or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests.

(33) "Government money market mutual fund" means a money market mutual fund that at all times:

(a) invests only in obligations issued, guaranteed, or insured by the federal government of the United States or collateralized repurchase agreements composed of these obligations; and

(b) qualifies for investment without a reserve under the Purposes and Procedures of the Securities Valuation Office or any successor publication.

(34) "Government-sponsored enterprise" means a:

(a) governmental agency; or

(b) corporation, limited liability company, association, partnership, joint-stock company, joint venture, trust, or other entity or instrumentality organized under the laws of any domestic jurisdiction to accomplish a public policy or other governmental purpose.

(35) "Guaranteed or insured", when used in connection with an obligation acquired under this chapter, means that the guarantor or insurer has agreed to:

(a) perform or insure the obligation of the obligor or purchase the obligation; or

(b) be unconditionally obligated until the obligation is repaid to maintain in the obligor a minimum net worth, fixed charge coverage, stockholders' equity, or sufficient liquidity to enable the obligor to pay the obligation in full.

(36) "Hedging transaction" means a derivative transaction that is entered into and maintained to reduce:

(a) the risk of a change in the value, yield, price, cash flow, or quantity of assets or liabilities that the insurer has acquired or incurred or anticipates acquiring or incurring; or

(b) the currency exchange rate risk or the degree of exposure as to assets or liabilities that an insurer has acquired or incurred or anticipates acquiring or incurring.

(37) "High-grade investment" means a rated credit instrument rated 1 or 2 by the SVO.

(38) "Highly rated" means an investment rated "P-1" by Moody's investors service, inc. or "A-1" by Standard and Poor's division of the McGraw Hill companies, inc. or its equivalent rating by a nationally recognized statistical rating organization recognized by the SVO.

(39) "Income" means, as to a security, interest, accrual of discount, dividends, or other distributions, such as rights, tax or assessment credits, warrants, and distributions in kind.

(40) "Income generation transaction" means a derivative transaction involving the writing of covered call options, covered put options, covered caps, or covered floors that is intended to generate income or enhance return.

(41) "Insurance future" means a future relating to an index or pool that is based on insurance-related items.

(42) "Insurance futures option" means an option on an insurance future.

(43) "Investment company" means an investment company as defined in section 80a-3 of the Investment Company Act of 1940 (15 U.S.C. 80a-1, et seq.), as amended, and a person described in section 80a-3(c) of that act.

(44) "Investment company series" means an investment portfolio of an investment company that is organized as a series company and to which assets of the investment company have been specifically allocated.

(45) "Investment practices" means transactions of the types described in 33-12-208, 33-12-210, 33-12-308, or 33-12-310.

(46) "Investment strategies" means the techniques and methods used by an insurer to meet its investment objectives, such as active bond portfolio management, passive bond portfolio management, interest rate anticipation, growth investing, and value investing.

(47) "Investment subsidiary" means a subsidiary of an insurer engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer if each subsidiary agrees to limit its investment in any asset so that its investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations or avoid any other provisions of this chapter applicable to the insurer.

(48) "Letter of credit" means a clean, irrevocable, and unconditional letter of credit issued or confirmed by and payable and presentable at a financial institution on the list of financial institutions meeting the standards for issuing letters of credit under the Purposes and Procedures of the Securities Valuation Office or any successor publication.

(49) "Limited liability company" means a business organization, excluding partnerships and ordinary business corporations, organized or operating under the laws of the United States or any state that limits the personal liability of investors to the equity investment of the investor in the business entity.

(50) "Lower-grade investment" means a rated credit instrument rated 4, 5, or 6 by the SVO.

(51) "Market value" means:

(a) as to cash and letters of credit, the amounts of cash or a letter of credit; and

(b) as to a security, as of any date, the price for the security on that date obtained from a generally recognized source or the most recent quotation from a generally recognized source or, to the extent that a generally recognized source does not exist, the price for the security as determined in good faith by the parties to a transaction, plus accrued but unpaid income on a security to the extent not included in the price as of that date.

(52) "Medium-grade investment" means a rated credit instrument rated 3 by the SVO.

(53) "Money market mutual fund" means a mutual fund that meets the conditions of 17 CFR 270.2a-7, under the Investment Company Act of 1940 (15 U.S.C. 80a-1, et seq.), as amended or renumbered.

(54) "Mortgage loan" means an obligation secured by a mortgage, deed of trust, trust deed, or other consensual lien on real estate.

(55) "Multilateral development bank" means an international development organization of which the United States is a member.

(56) "Mutual fund" means an investment company or an investment company series that is registered with the United States securities and exchange commission under the Investment Company Act of 1940 (15 U.S.C. 80a-1, et seq.), as amended.

(57) "NAIC" means the national association of insurance commissioners.

(58) "Obligation" means a bond, note, debenture, trust certificate including an equipment certificate, production payment, negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, loan secured by financing net leases, and other evidence of indebtedness for the payment of money (or participations, certificates, or other evidences of an interest in any

of the foregoing), whether constituting a general obligation of the issuer or payable only out of certain revenue or certain funds pledged or otherwise dedicated for payment.

(59) "Option" means an agreement giving the buyer the right to buy or receive (a "call option"), sell or deliver (a "put option"), enter into, extend or terminate, or effect a cash settlement based on the actual or expected price, level, performance, or value of one or more underlying interests.

(60) "Person" has the meaning provided in 33-1-202.

(61) "Potential exposure" means the amount determined in accordance with the NAIC Annual Statement Instructions.

(62) "Preferred stock" means preferred, preference, or guaranteed stock of a business entity authorized to issue the stock that has a preference in liquidation over the common stock of the business entity.

(63) "Qualified bank" means:

(a) a national bank, state bank, or trust company that at all times is adequately capitalized as determined by standards adopted by United States banking regulators and that is either regulated by state banking laws or is a member of the federal reserve system; or

(b) a bank or trust company incorporated or organized under the laws of a country other than the United States that is regulated as a bank or trust company by that country's government or an agency of that government and that at all times is adequately capitalized as determined by the standards adopted by international banking authorities.

(64) "Qualified business entity" means a business entity that is:

(a) an issuer of obligations or preferred stock that is rated 1 or 2 by the SVO or an issuer of obligations, preferred stock, or derivative instruments that are rated the equivalent of 1 or 2 by the SVO or by a nationally recognized statistical rating organization recognized by the SVO; or

(b) a primary dealer in United States government securities recognized by the federal reserve bank of New York.

(65) "Qualified clearinghouse" means a clearinghouse for, and subject to the rules of, a qualified exchange or a qualified foreign exchange, which provides clearing services, including acting as a counterparty to each of the parties to a transaction so that the parties no longer have a credit risk as to each other.

(66) "Qualified exchange" means:

(a) a securities exchange registered as a national securities exchange or a securities market regulated under the Securities Exchange Act of 1934 (15 U.S.C. 78, et seq.), as amended;

(b) a board of trade or commodities exchange designated as a contract market by the commodity futures trading commission or its successor;

(c) private offerings, resales, and trading through automated linkages;

(d) a designated offshore securities market as defined in securities exchange commission regulation S, 17 CFR part 230, as amended; or

(e) a qualified foreign exchange.

(67) "Qualified foreign exchange" means a foreign exchange, board of trade, or contract market located outside the United States or its territories or possessions:

(a) that has received regulatory comparability relief under commodity futures trading commission rule 30.1 (as set forth in appendix C to part 30 of the regulations, 17 CFR part 30);

(b) that is, or its members are, subject to the jurisdiction of a foreign futures authority that has received regulatory comparability relief under commodity futures trading commission rule 30.1 (as set forth in appendix C to part 30 of the regulations, 17 CFR part 30) as to futures transactions in the jurisdiction where the exchange, board of trade, or contract market is located; or

(c) upon which foreign stock index futures contracts are listed that are the subject of no-action relief issued by the CFTC's office of general counsel, provided that an exchange, board of trade, or contract market that qualifies as a qualified foreign exchange only under this subsection (67) is a qualified foreign exchange as to foreign stock index futures contracts that are the subject of no-action relief.

(68) "Qualified guarantor" means a guarantor against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(69) "Qualified primary credit source" means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction.

(70) (a) "Rated credit instrument" means a contractual right to receive cash or another rated credit instrument from another entity if the instrument:

(i) is rated or required to be rated by the SVO;

(ii) in the case of an instrument with a maturity of 397 days or less, is issued, guaranteed, or insured by an entity that is rated by, or another obligation of the entity is rated by, the SVO or by a nationally recognized statistical rating organization recognized by the SVO;

(iii) in the case of an instrument with a maturity of 90 days or less, is issued by a qualified bank;

(iv) is a share of a class one bond mutual fund; or

(v) is a share of a money market mutual fund.

(b) The term does not include:

(i) an instrument that is mandatorily or at the option of the issuer convertible to an equity interest; or

(ii) a security that has a par value and whose terms provide that the issuer's net obligation to repay all or part of the security's par value is determined by reference to the performance of an equity, a commodity, a foreign currency, an index of equities, commodities, foreign currencies, or combinations of equities, commodities, and foreign currency.

(71) (a) "Real estate" means:

(i) real property;

(ii) interests in real property, such as leaseholds, minerals, oil, and gas, that have not been separated from the underlying fee interest;

(iii) improvements and fixtures located on or in real property; and

(iv) the seller's equity in a contract providing for a deed of real estate.

(b) As to a mortgage on a leasehold estate, real estate includes the leasehold estate only if it has an unexpired term, including renewal options exercisable at the option of the lessee, extending beyond the scheduled maturity date of the obligation that is secured by a mortgage on the leasehold estate by a period equal to at least 20% of the original term of the obligation or 10 years, whichever is greater.

(72) "Replication transaction" means a derivative transaction that is intended to replicate the performance of one or more assets that an insurer is authorized to acquire under this chapter. A derivative transaction that is entered into as a hedging transaction may not be considered a replication transaction.

(73) "Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

(74) "Required liabilities" means total liabilities required to be reported on the statutory financial statement of the insurer most recently required to be filed with the commissioner.

(75) "Residential mortgage loan" means a loan primarily secured by a mortgage on real estate improved with a residence for no more than four families.

(76) "Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

(77) "Secured location" means the contiguous real estate owned by one person.

(78) "Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loaned securities or equivalent securities to the insurer, either within a specified period of time or upon demand.

(79) "Series company" means an investment company that is organized as a series company, as defined in rules adopted under the Investment Company Act of 1940 (15 U.S.C. 80a-1, et seq.), as amended.

(80) "Shell business entity" means a business entity having no economic substance, except as a vehicle for owning interests in assets issued, owned, or previously owned by a person domiciled in a foreign jurisdiction.

(81) "Short-term" means investments with a remaining term to maturity of 90 days or less.

(82) "Sinking fund stock" means preferred stock that:

(a) is subject to a mandatory sinking fund or similar arrangement that will provide for the redemption or open market purchase of the entire issue over a period not longer than 40 years from the date of acquisition; and

(b) provides for mandatory sinking fund installments or open market purchases commencing not more than 10½ years from the date of issue, with the sinking fund installments providing for the purchase or redemption, on a cumulative basis commencing 10 years from the date of issue, of at least 2.5% a year of the original number of shares of that issue of preferred stock.

(83) "State" has meaning provided in 33-1-201.

(84) "Substantially similar securities" means securities that meet all criteria for substantially similar specified in the NAIC Accounting Practices and Procedures Manual, as amended, and in an amount that constitutes good delivery form as determined from time to time by the public securities administration.

(85) "SVO" means the securities valuation office of the NAIC or any successor office established by the NAIC.

(86) "Swap" means an agreement to exchange or to net payments at one or more times based on the actual or expected price, level, performance, or value of one or more underlying interests.

(87) "Total investment of the insurer" includes:

(a) direct investment by the insurer in an asset; and

(b) the insurer's proportionate share of an investment in an asset by an investment subsidiary of the insurer, which must be calculated by multiplying the amount of the subsidiary's investment by the percentage of the insurer's ownership interest in the subsidiary.

(88) "Underlying interest" means the assets, liabilities, other interests, or a combination of assets, liabilities, or other interests underlying a derivative instrument, such as any one or more securities, currencies, rates, indices, commodities, or derivative instruments.

(89) "Unrestricted surplus" means the amount by which total admitted assets exceed 125% of the insurer's required liabilities.

(90) "Warrant" means an instrument that gives the holder the right to purchase an underlying financial instrument at a given price and time or at a series of prices and times outlined in the warrant agreement. Warrants may be issued alone or in connection with the sale of other securities, for example, as part of a merger or recapitalization agreement, or to facilitate divestiture of the securities of another business entity.

History: En. Sec. 2, Ch. 304, L. 1999.

33-12-103. General investment qualifications. (1) Insurers may acquire, hold, or invest in investments or engage in investment practices as set forth in this chapter. Investments not conforming to this chapter may not be admitted assets. Affiliate investments under 33-2-1103, other than those investments made by or on behalf of domestic insurers, are not subject to this provision.

(2) Subject to subsection (3), an insurer may not acquire or hold an investment as an admitted asset unless at the time of acquisition it is:

(a) (i) eligible for the payment or accrual of interest or discount, whether in cash or other securities;

(ii) eligible to receive dividends or other distributions; or

(iii) otherwise income-producing; or

(b) acquired under 33-12-207(3), 33-12-208, 33-12-210, 33-12-212, 33-12-307(3), 33-12-308, 33-12-310, or 33-12-311 or under the authority of sections of Montana law other than this chapter.

(3) An insurer may acquire or hold as admitted assets investments that do not otherwise qualify as provided in this chapter if the insurer has not acquired them for the purpose

of circumventing any limitations contained in this chapter and if the insurer complies with the provisions of 33-12-105 and 33-12-108 and acquires the investments in the following circumstances:

(a) as payment on account of existing indebtedness or in connection with the refinancing, restructuring, or workout of existing indebtedness if taken to protect the insurer's interest in that investment;

(b) as realization on collateral for an obligation;

(c) in connection with an otherwise qualified investment or investment practice, as interest on or a dividend or other distribution related to the investment or investment practice, or in connection with the refinancing of the investment, in each case for no additional or only nominal consideration;

(d) under a lawful and bona fide agreement of recapitalization or voluntary or involuntary reorganization in connection with an investment held by the insurer; or

(e) under a bulk reinsurance, merger, or consolidation transaction approved by the commissioner if the assets constitute admissible investments for the ceding, merged, or consolidated companies.

(4) An investment or portion of an investment acquired by an insurer under subsection (3) must become a nonadmitted asset 3 years, or 5 years in the case of mortgage loans and real estate, from the date of its acquisition, unless within that period the investment has become a qualified investment under a provision of this chapter other than subsection (3). However, an investment acquired under an agreement of bulk reinsurance, merger, or consolidation may be qualified for a longer period if provided for in the plan for reinsurance, merger, or consolidation as approved by the commissioner. Upon application by the insurer and a showing that the nonadmission of an asset held under subsection (3) would materially injure the interests of the insurer, the commissioner may extend the period for admissibility for an additional reasonable period of time.

(5) Except as provided in subsections (6) and (8), an investment must qualify under this chapter if, on the date the insurer committed to acquire the investment or on the date of its acquisition, it would have qualified under this chapter. For the purposes of determining limitations contained in this chapter, an insurer shall give appropriate recognition to any commitments to acquire investments.

(6) (a) An investment held as an admitted asset by an insurer on July 1, 1999, that qualified under former law remains qualified as an admitted asset under this chapter.

(b) Each specific transaction constituting an investment practice of the type described in this chapter that was lawfully entered into by an insurer and was in effect on July 1, 1999, continues to be permitted under this chapter until its expiration or termination under its terms.

(7) Unless otherwise specified, an investment limitation computed on the basis of an insurer's admitted assets or capital and surplus relates to the amount required to be shown on the most recent statutory balance sheet of the insurer required to be filed with the commissioner. For purposes of computing any limitation based upon admitted assets, the insurer shall deduct from the amount of its admitted assets the amount of the liability recorded on its statutory balance sheet for:

(a) the return of acceptable collateral received in a reverse repurchase transaction or a securities lending transaction;

(b) cash received in a dollar roll transaction; and

(c) the amount reported as borrowed money in the most recently filed financial statement to the extent not included in subsections (7)(a) and (7)(b).

(8) An investment qualified, in whole or in part, for acquisition or holding as an admitted asset may be qualified or requalified at the time of acquisition or a later date, in whole or in part, under any other section if the relevant conditions contained in the other section are satisfied at the time of qualification or requalification.

(9) An insurer shall maintain documentation demonstrating that investments were acquired in accordance with this chapter.

(10) An insurer may not enter into an agreement to purchase securities in advance of their issuance for resale to the public as part of a distribution of the securities by the issuer

or otherwise guarantee the distribution, except that an insurer may acquire privately placed securities with registration rights.

(11) Notwithstanding the provisions of this chapter, the commissioner, for good cause, may under the Montana Administrative Procedure Act order an insurer to nonadmit, limit, dispose of, withdraw from, or discontinue an investment or investment practice. The authority of the commissioner under this subsection is in addition to any other authority of the commissioner.

(12) Insurance futures and insurance futures options are not considered investments or investment practices for purposes of this chapter.

History: En. Sec. 3, Ch. 304, L. 1999; amd. Sec. 36, Ch. 227, L. 2001.

33-12-104. Authorization of investments by board of directors. (1) An insurer's board of directors shall adopt a written plan for acquiring and holding investments and for engaging in investment practices that specifies guidelines as to the quality, maturity, and diversification of investments and that contains other specifications including investment strategies intended to ensure that the investments and investment practices are appropriate for the business conducted by the insurer, its liquidity needs, and its capital and surplus.

(2) The board of directors is ultimately responsible for investment decisions and shall review, at least annually, whether all investments acquired and held under this chapter have been made in accordance with delegations, standards, limitations, and investment objectives prescribed by the board or a committee of the board charged with the responsibility to direct its investments.

(3) An insurer's board of directors or committee of the board of directors shall:

(a) on no less than a quarterly basis and more often if considered appropriate, receive and review a summary report on the insurer's investment portfolio, its investment activities, and investment practices engaged in under delegated authority, in order to determine whether the investment activity of the insurer is consistent with its written plan; and

(b) on no less than an annual basis and more often if considered appropriate, review and revise, as appropriate, the written plan.

(4) In discharging its duties under this section, the board of directors may require that records of any authorizations or approvals, other documentation as the board may require, and reports of any action taken under authority delegated under the plan referred to in subsection (1) may be made available on a regular basis to the board of directors.

(5) If an insurer does not have a board of directors, all references to the board of directors in this chapter are considered to be references to the governing body of the insurer having authority equivalent to that of a board of directors.

(6) In discharging their duties under this section, the directors of an insurer shall perform their duties as provided in 35-14-830.

History: En. Sec. 4, Ch. 304, L. 1999; amd. Sec. 237, Ch. 271, L. 2019.

33-12-105. Prohibited investments. (1) An insurer may not, directly or indirectly, without the prior written approval of the commissioner:

(a) invest in an obligation or security or make a guarantee for the benefit of or in favor of an officer or director of the insurer, except as provided in 33-12-106;

(b) invest in an obligation or security of, make a guarantee for the benefit of or in favor of, or make other investments in a business entity of which 10% or more of the voting securities or equity interests are owned directly or indirectly by or for the benefit of one or more officers or directors of the insurer, except as authorized in Title 33, chapter 2, part 11, or as provided in 33-12-106;

(c) engage on its own behalf or through one or more affiliates in a transaction or series of transactions designed to evade the prohibitions of this chapter; or

(d) except as provided in subsection (2), invest in or lend its funds upon the security of shares of its own stock.

(2) (a) An insurer may acquire shares of its own stock for the following purposes:

(i) conversion of a stock insurer into a mutual or reciprocal insurer or conversion of a mutual or reciprocal insurer into a stock insurer; or

(ii) issuance to the insurer's officers, employees, or agents in connection with a plan approved by the commissioner in connection with stock option and employee benefit plans.

(b) Shares of stock that are subject to subsection (2)(a) may not be admitted assets of the insurer.

(3) (a) An insurer may not, directly or indirectly, without the prior written approval of the commissioner invest in a partnership as a general partner, except that an insurer may make an investment as a general partner:

(i) if all other partners in the partnership are subsidiaries of the insurer;

(ii) for the purpose of:

(A) meeting cash calls committed to prior to July 1, 1999;

(B) completing those specific projects or activities of the partnership in which the insurer was a general partner as of July 1, 1999, that had been undertaken as of July 1, 1999; or

(C) making capital improvements to property owned by the partnership on July 1, 1999, if the insurer was a general partner as of July 1, 1999; or

(iii) in accordance with 33-12-103(3).

(b) Subsection (3)(a) does not prohibit a subsidiary or other affiliate of the insurer from becoming a general partner.

History: En. Sec. 5, Ch. 304, L. 1999.

33-12-106. Loans to officers and directors. (1) (a) Except as provided in subsection (2), an insurer may not, directly or indirectly, without the prior written approval of the commissioner:

(i) make a loan to an officer or director of the insurer or make another investment in a person in which the officer or director has any direct or indirect financial interest;

(ii) make a guarantee for the benefit of or in favor of an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest; or

(iii) enter into an agreement for the purchase or sale of property from or to an officer or director of the insurer or a person in which the officer or director has any direct or indirect financial interest.

(b) For purposes of this section, an officer or director may not have a financial interest by reason of an interest that is held directly or indirectly through the ownership of equity interests representing less than 2% of all outstanding equity interests issued by a person that is a party to the transaction or solely by reason of that individual's position as a director or officer of a person that is a party to the transaction.

(c) This subsection (1) does not permit an investment that is prohibited by 33-12-105.

(d) This subsection (1) does not apply to a transaction between an insurer and any of its subsidiaries or affiliates that is entered into in compliance with Title 33, chapter 2, part 11, other than a transaction between an insurer and its officer or director.

(2) An insurer may, without the prior written approval of the commissioner, make any of the following:

(a) policy loans in accordance with the terms of the policy or contract and 33-12-211;

(b) advances to officers or directors for expenses reasonably expected to be incurred in the ordinary course of the insurer's business or guarantees associated with credit or charge cards issued or credit extended for the purpose of financing these expenses;

(c) loans secured by the principal residence of an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request if the loans comply with the requirements of 33-12-207 or 33-12-307 and the terms and conditions are the same as those generally available from unaffiliated third parties;

(d) secured loans to an existing or new officer of the insurer made in connection with the officer's relocation at the insurer's request if the loans:

(i) do not have a term exceeding 2 years;

(ii) are required to finance mortgage loans outstanding at the same time on the prior and new residences of the officer;

(iii) do not exceed an amount equal to the equity of the officer in the prior residence; and

(iv) are required to be fully repaid upon the earlier of the end of the 2-year period or the sale of the prior residence; or

(e) loans and advances to officers or directors made in compliance with state or federal law specifically related to the loans and advances by a regulated noninsurance subsidiary or affiliate of the insurer in the ordinary course of business and on terms no more favorable than available to other customers of the entity.

History: En. Sec. 6, Ch. 304, L. 1999.

33-12-107. Valuation of investments. For the purposes of this chapter, the value or amount of an investment acquired or held under this chapter or an investment practice engaged in under this chapter, unless otherwise specified in statute, must be the value at which assets of an insurer are required to be reported for statutory accounting purposes as determined in accordance with procedures prescribed in published accounting and valuation standards of the NAIC, including the Purposes and Procedures Manual of the Securities Valuation Office, the Valuation of Securities Manual, the Accounting Practices and Procedures Manual, the annual statement instructions, or any successor valuation procedures officially adopted by the NAIC.

History: En. Sec. 7, Ch. 304, L. 1999; amd. Sec. 10, Ch. 469, L. 2005.

33-12-108. Presumption of control. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10% or more of the voting securities of another person. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may determine, after furnishing all interested persons notice and an opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

History: En. Sec. 8, Ch. 304, L. 1999.

33-12-109. Credit risk attributable to derivative statement. (1) The amount of credit risk equals:

(a) the market value of the over-the-counter derivative instrument if the liquidation of the derivative instrument would result in a final cash payment to the insurer; or

(b) zero if the liquidation of the derivative instrument would not result in a final cash payment to the insurer.

(2) If over-the-counter derivative instruments are entered into under a written master agreement that provides for netting of payments owed by the respective parties and the domiciliary jurisdiction of the counterparty is either within the United States or if not within the United States, within a foreign jurisdiction listed in the Purposes and Procedures of the Securities Valuation Office as eligible for netting, the net amount of credit risk must be the greater of zero or the net sum of:

(a) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment to the insurer; and

(b) the market value of the over-the-counter derivative instruments entered into under the agreement, the liquidation of which would result in a final cash payment by the insurer to the business entity.

(3) For open transactions, market value must be determined at the end of the most recent quarter of the insurer's fiscal year and must be reduced by the market value of acceptable collateral held by the insurer or placed in escrow by one or both parties.

History: En. Sec. 9, Ch. 304, L. 1999.

33-12-110. Special rated credit instrument. (1) (a) Subject to subsection (1)(b), a rated credit instrument is a special rated credit instrument if it is an instrument that is:

(i) structured so that if it is held until retired by or on behalf of the issuer, its rate of return, based on its purchase cost and any cash flow stream possible under the structure of the transaction, may become negative because of reasons other than the credit risk associated with the issuer of the instrument; or

(ii) an asset-backed security that:

(A) relies on cash flows from assets that are prepayable at par at any time;

(B) does not make payments of par that are fixed as to amount and timing; and

(C) has a negative rate of return at the time of acquisition if a prepayment threshold assumption is used with the prepayment threshold assumption defined as either:

(I) two times the prepayment expectation reported by a recognized, publicly available source as being the median of expectations contributed by broker dealers or other entities, except insurers, engaged in the business of selling or evaluating the securities or assets. The prepayment expectation used in this calculation must be, at the insurer's election, the prepayment expectation for passthrough securities of the federal national mortgage association, the federal home loan mortgage corporation, or the government national mortgage association or for other assets of the same type as the assets that underlie the asset-backed security, in either case with a gross weighted average coupon comparable to the gross weighted average coupon of the assets that underlie the asset-backed security.

(II) another prepayment threshold assumption specified by the commissioner by rule adopted under 33-12-111.

(b) A rated credit instrument may not be a special rated credit instrument under this section if it is:

(i) a share in a class one bond mutual fund;

(ii) an instrument, other than an asset-backed security, with payments of par value fixed as to amount and timing or callable but in any event payable only at par or greater and with interest or dividend cash flows that are based on either a fixed or variable rate determined by reference to a specified rate or index;

(iii) an instrument, other than an asset-backed security, that has a par value and is purchased at a price no greater than 110% of par;

(iv) an instrument, including an asset-backed security, with a rate of return that would become negative only as a result of a prepayment due to casualty, condemnation, economic obsolescence of collateral, or change of law;

(v) an asset-backed security that relies on collateral that meets the requirements of subsection (1)(b)(ii), the par value of which collateral:

(A) is not permitted to be paid sooner than one-half of the remaining term to maturity from the date of acquisition;

(B) is permitted to be paid prior to maturity only at a premium sufficient to provide a yield to maturity for the investment, considering the amount prepaid and reinvestment rates at the time of early repayment, at least equal to the yield to maturity of the initial investment; or

(C) is permitted to be paid prior to maturity at a premium at least equal to the yield of a treasury issue of comparable remaining life; or

(vi) an asset-backed security that relies on cash flows from assets that are not prepayable at any time at par, but is not otherwise governed by subsection (1)(b)(v), if the asset-backed security has a par value reflecting principal payments to be received if held until retired by or on behalf of the issuer and is purchased at a price no greater than 105% of the par amount.

(2) For purposes of subsection (1), if the asset-backed security is purchased in combination with one or more other asset-backed securities that are supported by identical underlying collateral, the insurer may calculate the rate of return for these specific combined asset-backed securities in combination. The insurer shall maintain documentation demonstrating that the securities were acquired and are continuing to be held in combination.

History: **En. Sec. 10, Ch. 304, L. 1999.**

33-12-111. Rules. The commissioner may adopt rules implementing the provisions of this chapter.

History: **En. Sec. 11, Ch. 304, L. 1999.**

33-12-112. Foreign and alien insurers. A foreign insurer or an alien insurer, as those terms are defined in 33-1-201, shall maintain its investments according to the laws of its domicile. For purposes of this section, an alien insurer shall claim as its domicile the state where it maintains its principal deposit.

History: **En. Sec. 12, Ch. 304, L. 1999.**

33-12-113. Indemnification agreement. An insurer may contract with any national or state bank, trust company, or securities brokerage firm to act as custodian for the insurer's securities. The contract must contain an indemnification agreement stating that the custodian is obligated to indemnify the insurer for any loss of the insurer's securities in its custody resulting from the intentional or negligent act or omission of the custodian or the employee, officer, or agent of the custodian.

History: **En. Sec. 1, Ch. 109, L. 2005.**

Part 2
Life and Health Insurers

33-12-201. Applicability. This part applies to the investments and investment practices of life and health insurers, subject to the provisions of 33-12-101(2).

History: En. Sec. 13, Ch. 304, L. 1999.

33-12-202. General 5% diversification — medium-grade and lower-grade investments — Canadian investments. (1) (a) Except as otherwise specified in this chapter, an insurer may not acquire, directly or indirectly through an investment subsidiary, an investment under this chapter if, as a result of and after giving effect to the investment, the insurer would hold more than 5% of its admitted assets in investments of all kinds issued, assumed, accepted, insured, or guaranteed by a single person.

(b) The 5% limitation does not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(c) Asset-backed securities are subject to the limitations of subsection (1)(a). However, an insurer may not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity then held by the insurer would exceed 5% of its admitted assets.

(2) (a) An insurer may not acquire, directly or indirectly through an investment subsidiary, an investment under 33-12-203, 33-12-206, or 33-12-209 or counterparty exposure under 33-12-210(4) if, as a result of and after giving effect to the investment:

(i) the aggregate amount of medium-grade and lower-grade investments then held by the insurer would exceed 20% of its admitted assets;

(ii) the aggregate amount of lower-grade investments then held by the insurer would exceed 10% of its admitted assets;

(iii) the aggregate amount of investments rated 5 or 6 by the SVO then held by the insurer would exceed 3% of its admitted assets;

(iv) the aggregate amount of investments rated 6 by the SVO then held by the insurer would exceed 1% of its admitted assets; or

(v) the aggregate amount of medium-grade and lower-grade investments then held by the insurer that receive as cash income less than the equivalent yield for treasury issues with a comparative average life would exceed 1% of its admitted assets.

(b) An insurer may not acquire, directly or indirectly through an investment subsidiary, an investment under 33-12-203, 33-12-206, or 33-12-209 or counterparty exposure under 33-12-210(4) if, as a result of and after giving effect to the investment:

(i) the aggregate amount of medium-grade and lower-grade investments issued, assumed, guaranteed, accepted, or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed 1% of its admitted assets; or

(ii) the aggregate amount of lower-grade investments issued, assumed, guaranteed, accepted, or insured by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed 0.5% of its admitted assets.

(c) If an insurer attains or exceeds the limit of any one rating category referred to in this subsection (2), the insurer is precluded from acquiring investments in other rating categories subject to the specific and multicategory limits applicable to those investments.

(3) (a) An insurer may not acquire, directly or indirectly through an investment subsidiary, a Canadian investment authorized by this chapter if, as a result of and after giving effect to the investment, the aggregate amount of these investments then held by the insurer would exceed 40% of its admitted assets or if the aggregate amount of Canadian investments not acquired under 33-12-203(3) then held by the insurer would exceed 25% of its admitted assets.

(b) However, as to an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of subsection (3)(a) must be increased by the greater of:

(i) the amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(ii) 115% of the amount of the insurer's reserves and other obligations under contracts on lives or risks resident or located in Canada.

History: En. Sec. 14, Ch. 304, L. 1999; amd. Sec. 37, Ch. 227, L. 2001.

33-12-203. Rated credit instruments. (1) Subject to the limitations of subsection (7), an insurer may acquire rated credit instruments in accordance with this section.

(2) Subject to the limitations of 33-12-202(2), an insurer may acquire rated credit instruments issued, assumed, guaranteed, or insured by:

(a) the United States; or

(b) a government-sponsored enterprise of the United States, if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

(3) (a) Subject to the limitations of 33-12-202(2), an insurer may acquire rated credit instruments issued, assumed, guaranteed, or insured by:

(i) Canada; or

(ii) a government-sponsored enterprise of Canada, if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada.

(b) An insurer may not acquire an instrument under this subsection (3) if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this subsection (3) would exceed 40% of its admitted assets.

(4) (a) Subject to the limitations of 33-12-202(2), an insurer may acquire rated credit instruments, excluding asset-backed securities:

(i) issued by a government money market mutual fund, a class one money market mutual fund, or a class one bond mutual fund;

(ii) issued, assumed, guaranteed, or insured by a government-sponsored enterprise of the United States other than those eligible under subsection (2);

(iii) issued, assumed, guaranteed, or insured by a state, if the instruments are general obligations of the state; or

(iv) issued by a multilateral development bank.

(b) However, an insurer may not acquire an instrument of any one fund, enterprise, entity, or state under this subsection (4) if, as a result of and after giving effect to the investment, the aggregate amount of investments then held in any one fund, enterprise, entity, or state under this subsection (4) would exceed 10% of its admitted assets.

(5) Subject to the limitations of 33-12-202, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

(a) the aggregate amount of preferred stocks then held by the insurer under this subsection (5) does not exceed 20% of its admitted assets; and

(b) the aggregate amount of preferred stocks then held by the insurer under this subsection (5) that are not sinking fund stocks or rated P-1 or P-2 by the SVO does not exceed 10% of its admitted assets.

(6) Subject to the limitations of 33-12-202, in addition to those investments eligible under subsections (2) through (5) of this section, an insurer may acquire rated credit instruments that are not foreign investments.

(7) An insurer may not acquire special rated credit instruments under this section if, as a result of and after giving effect to the investment, the aggregate amount of special rated credit instruments then held by the insurer would exceed 5% of its admitted assets.

(8) The provisions of subsections (2) through (4) are not subject to the limitation provided in 33-12-202(1).

History: En. Sec. 15, Ch. 304, L. 1999; amd. Sec. 38, Ch. 227, L. 2001.

33-12-204. Insurer investment pools. (1) An insurer may acquire investments in investment pools that invest only in:

(a) (i) obligations that are rated 1 or 2 by the SVO or a nationally recognized statistical rating organization recognized by the SVO or in the absence of a 1 or 2 or equivalent rating, the issuer has outstanding obligations with an SVO rating of 1 or 2 or an equivalent rating and that have:

(A) remaining maturity of 397 days or less or a put option that entitles the holder to receive the principal amount of the obligation and the put option may be exercised through maturity at specified intervals not exceeding 397 days; or

(B) remaining maturity of 3 years or less and:

(I) a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index such as federal funds, prime rate, treasury bills, London interbank offered rate, or commercial paper; and

(II) is subject to no maximum limit if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(ii) government money market mutual funds or class one money market mutual funds; or

(iii) securities lending, repurchase, and reverse repurchase transactions that meet all the requirements of 33-12-208, except the quantitative limitations of 33-12-208(4); or

(b) investments that an insurer may acquire under this chapter if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this chapter.

(2) For an investment in an investment pool to be qualified under this chapter, the investment pool may not:

(a) acquire securities issued, assumed, guaranteed, or insured by the insurer or an affiliate of the insurer;

(b) borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of 33-12-208, except the quantitative limitations of 33-12-208(4); or

(c) permit the aggregate value of securities then loaned, sold to, purchased from, or invested in any one business entity under this section to exceed 10% of the total assets of the investment pool.

(3) The limitations of 33-12-202(1) do not apply to an insurer's investment in an investment pool. However, an insurer may not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section:

(a) in any one investment pool would exceed 10% of its admitted assets;

(b) in all investment pools investing in investments permitted under subsection (1)(b) would exceed 25% of its admitted assets; or

(c) in all investment pools would exceed 35% of its admitted assets.

(4) For an investment in an investment pool to be qualified under this chapter, the manager of the investment pool:

(a) must be organized under the laws of the United States or a state and designated as the pool manager in a pooling agreement;

(b) must be:

(i) the insurer, an affiliated insurer, a business entity affiliated with the insurer, a qualified bank, or a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. 80b-1, et seq.), as amended;

(ii) in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact; or

(iii) in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(c) shall compile and maintain detailed accounting records setting forth:

(i) the cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(ii) a complete description of all underlying assets of the investment pool, including amount, interest rate, maturity date, if any, and other appropriate designations; and

(iii) other records that, on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(d) shall maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement must:

(i) state and recognize the claims and rights of each participant;

(ii) acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(iii) contain an agreement that the underlying assets of the investment pool may not be commingled with the general assets of the custodian qualified bank or any other person.

(5) The pooling agreement for each investment pool must be in writing and must provide that:

(a) an insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under subsection (1)(a), the insurer and its subsidiaries or affiliates, any pension or profit-sharing plan of the insurer or its subsidiaries and affiliates, or in the case of a United States branch of an alien insurer, the affiliates or subsidiaries of its United States manager shall, at all times, hold 100% of the interests in the investment pool;

(b) the underlying assets of the investment pool may not be commingled with the general assets of the pool manager or any other person;

(c) in proportion to the aggregate amount of each pool participant's interest in the investment pool:

(i) each participant owns an undivided interest in the underlying assets of the investment pool; and

(ii) the underlying assets of the investment pool are held solely for the benefit of each participant;

(d) a participant or, in the event of the participant's insolvency, bankruptcy, or receivership, its trustee, receiver, or other successor in interest may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(e) withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds must occur within a reasonable and customary period not to exceed 5 business days. Distributions under this section must be calculated in each case net of all then-applicable fees and expenses of the investment pool. The pooling agreement must provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(i) in cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(ii) in kind, a pro rata share of each underlying asset; or

(iii) in a combination of cash and in-kind distributions, a pro rata share in each underlying asset.

(f) the pool manager shall make the records of the investment pool available for inspection by the commissioner.

History: **En. Sec. 16, Ch. 304, L. 1999.**

33-12-205. Equity interests. (1) Subject to the limitations of 33-12-202, an insurer may acquire equity interests in business entities organized under the laws of any domestic jurisdiction.

(2) An insurer may not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section would exceed 20% of its admitted assets or the amount of equity interests then held by the insurer that are not listed on a qualified exchange would exceed 5% of its admitted assets. An accident and health insurer is subject to this section but is subject to the same aggregate limitation on equity interests as a property and casualty insurer under 33-12-305 and is also subject to the provisions of 33-12-312.

(3) An insurer may not acquire under the provisions of this section any investments that the insurer may acquire under 33-12-207.

(4) An insurer may not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within 6 months of the short sale.

History: **En. Sec. 17, Ch. 304, L. 1999.**

33-12-206. Tangible personal property under lease. (1) (a) Subject to the limitations of 33-12-202, an insurer may acquire tangible personal property or equity interests in tangible personal property located or used wholly or in part within a domestic jurisdiction, either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by 33-12-104(4), joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments.

(b) Investments acquired under subsection (1)(a) are eligible only if:

(i) the property is subject to a lease or other agreement with a person whose rated credit instruments could be acquired by the insurer under 33-12-203 in the amount of the purchase price of the personal property; and

(ii) the lease or other agreement provides the insurer with the right to receive rental, purchase, or other fixed payments for the use or purchase of the property and the aggregate value of the payments, together with the estimated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, are adequate to return the cost of the insurer's investment in the property, plus a return considered adequate by the insurer.

(2) The insurer shall compute the amount of each investment under this section on the basis of the out-of-pocket purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses, to the extent the borrowing is without recourse to the insurer.

(3) An insurer may not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this section would exceed:

(a) 2% of its admitted assets; or

(b) 0.5% of its admitted assets as to any single item of tangible personal property.

(4) For purposes of determining compliance with the limitations of 33-12-202, investments acquired by an insurer under this section must be aggregated with those acquired under 33-12-203 and each lessee of the property under a lease referred to in this section is considered the issuer of an obligation in the amount of the investment of the insurer in the property determined as provided in subsection (2).

(5) Nothing in this section is applicable to tangible personal property lease arrangements between an insurer and its subsidiaries and affiliates under a cost-sharing arrangement or agreement permitted under Title 33, chapter 2, part 11.

History: En. Sec. 18, Ch. 304, L. 1999.

33-12-207. Mortgage loans — income-producing real estate — real estate for the accommodation of business — quantitative limitations. (1) Subject to the limitations of 33-12-203, an insurer may acquire obligations secured by mortgages on real estate situated within a domestic jurisdiction, either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by 33-12-104(4), joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments. However, a mortgage loan that is secured by other than a first lien may not be acquired unless the insurer is the holder of the first lien. The obligations held by the insurer and any obligations with an equal lien priority may not, at the time of acquisition of the obligation, exceed:

(a) 90% of the fair market value of the real estate if the mortgage loan is secured by a purchase money mortgage or similar security received by the insurer upon disposition of the real estate;

(b) 80% of the fair market value of the real estate if the mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period of 30 years or less, and has periodic payments made no less frequently than annually. Each periodic payment must be sufficient to ensure that at all times the outstanding principal balance of the mortgage loan is not greater than the outstanding principal balance that would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate, and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans permitted under this subsection (1)(b) are permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan. For residential mortgage loans, the 80% limitation may be increased to 97% if acceptable private mortgage insurance has been obtained.

(c) 75% of the fair market value of the real estate for mortgage loans that do not meet the requirements of subsection (1)(a) or (1)(b).

(2) For purposes of subsection (1)(a), the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the federal housing administration, guaranteed by the administrator of veterans affairs, or insured or guaranteed by their successors.

(3) A mortgage loan that is held by an insurer under 33-12-103(6) or that is acquired under this section and is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the NAIC Accounting Practices and Procedures Manual or a successor publication continues to qualify as a mortgage loan under this chapter.

(4) Subject to the limitations of 33-12-202, credit lease transactions that do not qualify for investment under 33-12-203 with the following characteristics are exempt from the provisions of subsection (1)(a) of this section:

(a) the loan amortizes over the initial fixed lease term in at least an amount sufficient so that the loan balance at the end of the lease term does not exceed the original appraised value of the real estate;

(b) the lease payments cover or exceed the total debt service over the life of the loan;

(c) a tenant or its affiliated entity with rated credit instruments that have an SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO has a full faith and credit obligation to make the lease payments;

(d) the insurer holds or is the beneficial holder of a first lien mortgage on the real estate;

(e) the expenses of the real estate are passed through to the tenant, excluding exterior, structural, parking, and heating, ventilation, and air-conditioning replacement expenses, unless annual escrow contributions, from cash flows derived from the lease payments, cover the expense shortfall; and

(f) there is a perfected assignment of the rents due pursuant to the lease to or for the benefit of the insurer.

(5) (a) An insurer may acquire, manage, and dispose of real estate situated in a domestic jurisdiction, either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by 33-12-104(4), joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate must be income-producing or intended for improvement or development for investment purposes under an existing program, in which case the real estate is considered to be income-producing.

(b) The real estate may be subject to mortgages, liens, or other encumbrances, the amount of which must, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsections (7)(b) and (7)(c).

(6) (a) An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the insurer's or the insurer's affiliates' business operations, including home office, branch office, and field office operations.

(b) Real estate acquired under this subsection (6) may include excess space for rent to others if the excess space, valued at its fair market value, would otherwise be a permitted investment under subsection (5) and is so qualified by the insurer.

(c) The real estate acquired under this subsection (6) may be subject to one or more mortgages, liens, or other encumbrances, the amount of which must, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsection (7)(d).

(d) For purposes of this subsection (6), business operations may not include that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds. An insurer may acquire real estate used for these purposes under subsection (5).

(7) (a) An insurer may not acquire an investment under subsection (1) if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under subsection (1) would exceed:

(i) 1% of its admitted assets in mortgage loans covering any one secured location;

(ii) 0.25% of its admitted assets in construction loans covering any one secured location; or

(iii) 2% of its admitted assets in construction loans in the aggregate.

(b) An insurer may not acquire an investment under subsection (5) if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments then held by the insurer under subsection (5) plus the guarantees then outstanding would exceed:

(i) 1% of its admitted assets in one parcel or group of contiguous parcels of real estate, except that this limitation does not apply to that portion of real estate used for the direct provision of health care services by an accident and health insurer for its insureds, such as hospitals, medical clinics, medical professional buildings, or other health facilities used for the purpose of providing health services; or

(ii) 15% of its admitted assets in the aggregate, but not more than 5% of its admitted assets as to properties that are to be improved or developed.

(c) An insurer may not acquire an investment under subsection (5) or (6) if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of all investments then held by the insurer under subsection (5) or (6) plus the guarantees then outstanding would exceed 45% of its admitted assets. However, an insurer may exceed this limitation by no more than 30% of its admitted assets if:

(i) this increased amount is invested only in residential mortgage loans;

(ii) the insurer has no more than 10% of its admitted assets invested in mortgage loans other than residential mortgage loans;

(iii) the loan-to-value ratio of each residential mortgage loan does not exceed 60% at the time the mortgage loan is qualified under this increased authority and the fair market value is supported by an appraisal no more than 2 years old prepared by an independent appraiser;

(iv) a single mortgage loan qualified under this increased authority may not exceed 0.5% of its admitted assets;

(v) the insurer files with the commissioner, and receives approval from the commissioner for, a plan that is designed to result in a portfolio of residential mortgage loans that is sufficiently geographically diversified; and

(vi) the insurer agrees to file annually with the commissioner records that demonstrate that its portfolio of residential mortgage loans is geographically diversified in accordance with the plan.

(d) The limitations of 33-12-202 do not apply to an insurer's acquisition of real estate under subsection (6). An insurer may not acquire real estate under subsection (6) if, as a result of and after giving effect to the acquisition, the aggregate amount of real estate then held by the insurer under subsection (6) would exceed 10% of its admitted assets. With the permission of the commissioner, additional amounts of real estate may be acquired under subsection (6).

History: **En. Sec. 19, Ch. 304, L. 1999.**

33-12-208. Securities lending, repurchase, reverse repurchase, and dollar roll transactions. (1) An insurer may enter into securities lending, repurchase, reverse repurchase, and dollar roll transactions with business entities, subject to the following requirements:

(a) The insurer's board of directors shall adopt a written plan that is consistent with the requirements of the written plan provided for in 33-12-104(1) and that specifies guidelines and objectives to be followed, such as:

(i) a description of how cash received will be invested or used for general corporate purposes of the insurer;

(ii) operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(iii) the extent to which the insurer may engage in these transactions.

(b) The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement must require that each transaction terminates no more than 1 year from its inception or upon the earlier demand of the insurer. The agreement must be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer if the agent is a qualified business entity and if the agreement:

(i) requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(ii) prohibits securities lending transactions under the agreement with the agent or its affiliates.

(c) Cash received in a transaction under this section must be invested in accordance with this chapter and in a manner that recognizes the liquidity needs of the transaction or must be used by the insurer for its general corporate purposes. For as long as the transaction remains outstanding, the insurer or its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book-entry systems of the federal reserve, depository trust company, participants trust company, or other securities depositories approved by the commissioner:

(i) possession of the acceptable collateral;

(ii) a perfected security interest in the acceptable collateral; or

(iii) in the case of a jurisdiction outside of the United States, title to or rights of a secured creditor to the acceptable collateral.

(d) The limitations of 33-12-202 and 33-12-209 do not apply to the business entity counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection (1)(d), effect may not be given to the insurer's future obligation to resell securities, in the case of a repurchase transaction, or to repurchase securities, in the case of a reverse repurchase transaction. An insurer may not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(i) the aggregate amount of securities then loaned, sold to, or purchased from any one business entity counterparty under this section would exceed 5% of the insurer's admitted assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement.

(ii) the aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this section would exceed 40% of the insurer's admitted assets.

(e) In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102% of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty is obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least 102% of the market value of the loaned securities.

(f) In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 95% of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than 95% of the market value of the securities transferred, the business entity counterparty is obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least 95% of the market value of the transferred securities.

(g) In a dollar roll transaction, the insurer must receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

(h) In a repurchase transaction, the insurer must receive as acceptable collateral transferred securities having a market value at least equal to 102% of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100% of the purchase price paid by the insurer, the business entity counterparty is obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least 102% of the purchase price. Securities acquired by an insurer in a repurchase transaction may not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(2) To constitute acceptable collateral for the purposes of this section, a letter of credit must have an expiration date beyond the term of the subject transaction.

History: En. Sec. 20, Ch. 304, L. 1999.

33-12-209. Foreign investments and foreign currency exposure. (1) Subject to the limitations of 33-12-202, an insurer may acquire foreign investments or engage in investment practices with persons of or in foreign jurisdictions if the investments or investment practices are of substantially the same types as those that an insurer is permitted to acquire under this chapter, other than of the type permitted under 33-12-204 and if, as a result of and after giving effect to the investment, the aggregate amount of foreign investments then held by the insurer under this subsection (1):

(a) does not exceed 20% of its admitted assets; and

(b) in a single foreign jurisdiction does not exceed 10% of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 3% of its admitted assets as to any other foreign jurisdiction.

(2) (a) Subject to the limitations of 33-12-202, an insurer may acquire investments or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under subsection (1) or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency, if the aggregate amount of investments then held by the insurer under this subsection (2) denominated in:

(i) foreign currencies does not exceed 10% of its admitted assets; and

(ii) the foreign currency of a single foreign jurisdiction does not exceed 10% of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 3% of its admitted assets as to any other foreign jurisdiction.

(b) However, an investment under subsection (2)(a) may not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under 33-12-210 and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate that effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.

(3) (a) In addition to investments permitted under subsections (1) and (2), an insurer that is authorized to do business in a foreign jurisdiction and that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction may acquire foreign investments respecting that foreign jurisdiction and may acquire investments denominated in the currency of that jurisdiction subject to the limitations of 33-12-202.

(b) However, investments made under this subsection (3) in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises are not subject to the limitations of 33-12-202 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection (3) may not exceed the greater of:

(i) the amount the insurer is required by the law of the foreign jurisdiction to invest in the foreign jurisdiction; or

(ii) 115% of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

(4) In addition to investments permitted under subsections (1) and (2), an insurer that is not authorized to do business in a foreign jurisdiction and that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction may acquire foreign investments respecting that foreign jurisdiction and may acquire investments denominated in the currency of that jurisdiction subject to the limitations of 33-12-202. However, investments made under this subsection in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises are not subject to the limitations of 33-12-202 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection may not exceed 105% of the amount of its reserves, net of reinsurance, and other obligations under the contracts on lives or risks resident or located in the foreign jurisdiction.

(5) Investments acquired under this section must be aggregated with investments of the same types made under this chapter and, in a similar manner, for purposes of determining compliance with the limitations, if any, contained in this chapter. Investments in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises, except for those exempted under subsections (3) and (4), are subject to the limitations of 33-12-202.

History: **En. Sec. 21, Ch. 304, L. 1999.**

33-12-210. Derivative transactions. An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the following conditions:

(1) (a) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income-generation transactions as provided in rules adopted by the commissioner.

(b) An insurer must be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of the transactions through cash flow testing or other appropriate analyses.

(2) An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(a) the aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed 5% of its admitted assets;

(b) the aggregate statement value of options, caps, and floors written in hedging transactions does not exceed 3% of its admitted assets; and

(c) the aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed 6.5% of its admitted assets.

(3) An insurer may enter into the following types of income-generation transactions only if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed-income assets that are subject to call or that generate the cash flows for payments under the caps or floors, plus the face value of fixed income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the put options does not exceed 10% of its admitted assets:

(a) sales of covered call options on noncallable, fixed-income securities, callable fixed-income securities if the option expires by its terms prior to the end of the noncallable period, or derivative instruments based on fixed-income securities;

(b) sales of covered call options on equity securities if the insurer holds in its portfolio or can immediately acquire, through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold;

(c) sales of covered put options on investments that the insurer is permitted to acquire under this chapter if the insurer has placed in escrow or entered into a custodian agreement segregating cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put option during the complete term of the put option sold; or

(d) sales of covered caps or floors if the insurer holds in its portfolio the investments generating the cash flow to make the required payments under the caps or floors during the complete term that the cap or floor is outstanding.

(4) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of 33-12-202.

(5) Pursuant to rules adopted under 33-12-111, the commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of subsection (2) or for other risk management purposes under rules adopted by the commissioner, but replication transactions may not be permitted for other than risk management purposes.

History: En. Sec. 22, Ch. 304, L. 1999.

33-12-211. Policy loans. A life insurer may lend to a policyholder, on the security of the cash surrender value of the policyholder's policy, a sum not exceeding the legal reserve that the insurer is required to maintain on the policy.

History: En. Sec. 23, Ch. 304, L. 1999.

33-12-212. Additional investment authority. (1) Under this subsection (1), an insurer may acquire an investment or may engage in investment practices described in 33-12-208 solely for the purpose of acquiring investments that exceed the quantitative limitations of 33-12-202 through 33-12-209. However, an insurer may not acquire an investment or engage in investment practices described in 33-12-208 under this subsection (1) if, as a result of and after giving effect to the transaction:

(a) the aggregate amount of investments then held by an insurer under this subsection (1) would exceed 5% of its admitted assets; or

(b) the aggregate amount of investments as to a limitation in 33-12-202 through 33-12-209 then held by the insurer under this subsection (1) would exceed 1% of its admitted assets.

(2) (a) In addition to the authority provided under subsection (1), an insurer may acquire under this subsection (2) an investment of any kind or engage in investment practices described in 33-12-208 that are not specifically prohibited by this chapter without regard to the categories, conditions, standards, or other limitations of 33-12-202 through 33-12-209 if, as a result of and after giving effect to the transaction, the aggregate amount of investments then held under this subsection (2) would not exceed the lesser of:

(i) 10% of its admitted assets; or

(ii) 75% of its capital and surplus.

(b) However, an insurer may not acquire any investment or engage in any investment practice under this subsection (2) if, as a result of and after giving effect to the transaction, the aggregate amount of all investments in any one person then held by the insurer under this subsection (2) would exceed 5% of its admitted assets.

(3) In addition to the investments acquired under subsections (1) and (2), an insurer may acquire under this subsection (3) an investment of any kind or engage in investment practices described in 33-12-208 that are not specifically prohibited by this chapter without regard to any limitations of 33-12-202 through 33-12-209 if:

(a) the commissioner grants prior approval;

(b) the insurer demonstrates that its investments are being made in a prudent manner and that the additional amounts will be invested in a prudent manner; and

(c) as a result of and after giving effect to the transaction, the aggregate amount of investments then held by the insurer under this subsection (3) does not exceed the greater of:

(i) 25% of its capital and surplus; or

(ii) 100% of capital and surplus less 10% of its admitted assets.

(4) An investment prohibited under 33-12-105 that is not permitted under 33-12-210 or additional derivative instruments acquired under 33-12-210 may not be acquired under this section.

History: En. Sec. 24, Ch. 304, L. 1999; amd. Sec. 39, Ch. 227, L. 2001.

Part 3
Property and Casualty, Financial Guaranty, Mortgage Guaranty, Surety, Marine, and Title Insurers

33-12-301. Applicability. Subject to the provisions of 33-12-101(2), this part applies to the investments and investment practices of property and casualty, financial guaranty, mortgage guaranty, surety, marine, and title insurers.

History: En. Sec. 25, Ch. 304, L. 1999.

33-12-302. General 5% diversification — medium-grade and lower-grade investments — Canadian investments. (1) (a) Except as otherwise specified in this chapter, an insurer may not acquire, directly or indirectly through an investment subsidiary, an investment under this chapter if, as a result of and after giving effect to the investment, the insurer would hold more than 5% of its admitted assets in investments of all kinds issued, assumed, accepted, insured, or guaranteed by a single person.

(b) The 5% limitation in subsection (1)(a) does not apply to the aggregate amounts insured by a single financial guaranty insurer with the highest generic rating issued by a nationally recognized statistical rating organization.

(c) Asset-backed securities are not subject to the limitations of subsection (1)(a). However, an insurer may not acquire an asset-backed security if, as a result of and after giving effect to the investment, the aggregate amount of asset-backed securities that are secured by or evidencing an interest in a single asset or single pool of assets held by a trust or other business entity and that are then held by the insurer would exceed 5% of its admitted assets.

(2) (a) An insurer may not acquire, directly or indirectly through an investment subsidiary, an investment under 33-12-303, 33-12-306, or 33-12-309 or counterparty exposure under 33-12-310(4) if, as a result of and after giving effect to the investment:

(i) the aggregate amount of all medium-grade and lower-grade investments then held by the insurer would exceed 20% of its admitted assets;

(ii) the aggregate amount of lower-grade investments then held by the insurer would exceed 10% of its admitted assets;

(iii) the aggregate amount of investments rated 5 or 6 by the SVO then held by the insurer would exceed 5% of its admitted assets;

(iv) the aggregate amount of investments rated 6 by the SVO then held by the insurer would exceed 1% of its admitted assets; or

(v) the aggregate amount of medium-grade and lower-grade investments then held by the insurer that receive as cash income less than the equivalent yield for treasury issues with a comparative average life would exceed 1% of its admitted assets.

(b) An insurer may not acquire, directly or indirectly through an investment subsidiary, an investment under 33-12-303, 33-12-306, or 33-12-309 or counterparty exposure under 33-12-310(4) if, as a result of and after giving effect to the investment:

(i) the aggregate amount of medium-grade and lower-grade investments issued, assumed, accepted, insured, or guaranteed by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed 1% of its admitted assets; or

(ii) the aggregate amount of lower-grade investments issued, assumed, accepted, insured, or guaranteed by any one person or, as to asset-backed securities secured by or evidencing an interest in a single asset or pool of assets, then held by the insurer would exceed 0.5% of its admitted assets.

(c) If an insurer attains or exceeds the limit of any one rating category referred to in this subsection (2), the insurer is not precluded from acquiring investments in other rating categories subject to the specific and multicategory limits applicable to those investments.

(3) (a) An insurer may not acquire, directly or indirectly through an investment subsidiary, any Canadian investments authorized by this chapter if as a result of and after giving effect to the investment, the aggregate amount of the investments then held by the insurer would exceed 40% of its admitted assets or if the aggregate amount of Canadian investments not acquired under 33-12-303(1)(b) then held by the insurer would exceed 25% of its admitted assets.

(b) However, as to an insurer that is authorized to do business in Canada or that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in Canada and denominated in Canadian currency, the limitations of subsection (3)(a) must be increased by the greater of:

(i) the amount the insurer is required by Canadian law to invest in Canada or to be denominated in Canadian currency; or

(ii) 125% of the amount of its reserves and other obligations under contracts on risks resident or located in Canada.

History: En. Sec. 26, Ch. 304, L. 1999.

33-12-303. Rated credit instruments. (1) Subject to the limitations of subsection (2), an insurer may acquire rated credit instruments in accordance with the following:

(a) Subject to the limitations of 33-12-302(2), but not to the limitations of 33-12-302(1), an insurer may acquire rated credit instruments issued, assumed, insured, or guaranteed by:

(i) the United States; or

(ii) a government-sponsored enterprise of the United States, if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by the United States or are otherwise backed or supported by the full faith and credit of the United States.

(b) (i) Subject to the limitations of 33-12-302(2), but not to the limitations of 33-12-302(1), an insurer may acquire rated credit instruments issued, assumed, insured, or guaranteed by:

(A) Canada; or

(B) a government-sponsored enterprise of Canada, if the instruments of the government-sponsored enterprise are assumed, guaranteed, or insured by Canada or are otherwise backed or supported by the full faith and credit of Canada.

(ii) However, an insurer may not acquire an instrument under this subsection (1)(b) if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this subsection (1)(b) would exceed 40% of its admitted assets.

(c) (i) Subject to the limitations of 33-12-302(2), but not to the limitations of 33-12-302(1), an insurer may acquire rated credit instruments, excluding asset-backed securities:

(A) issued by a government money market mutual fund, a class one money market mutual fund, or a class one bond mutual fund;

(B) issued, assumed, insured, or guaranteed by a government-sponsored enterprise of the United States other than those eligible under subsection (1)(a);

(C) issued, assumed, insured, or guaranteed by a state if the instruments are general obligations of the state; or

(D) issued by a multilateral development bank.

(ii) However, an insurer may not acquire an instrument of any one fund, any one enterprise or entity, or any one state under this subsection (1)(c) if, as a result of and after giving effect to the investment, the aggregate amount of investments then held in any one fund, enterprise, entity, or state under this subsection (1)(c) would exceed 10% of its admitted assets.

(d) Subject to the limitations of 33-12-302, an insurer may acquire preferred stocks that are not foreign investments and that meet the requirements of rated credit instruments if, as a result of and after giving effect to the investment:

(i) the aggregate amount of preferred stocks then held by the insurer under this subsection (1)(d) does not exceed 20% of its admitted assets; and

(ii) the aggregate amount of preferred stocks then held by the insurer under this subsection (1)(d) that are not sinking fund stocks or rated P-1 or P-2 by the SVO does not exceed 10% of its admitted assets.

(e) Subject to the limitations of 33-12-302, in addition to those investments eligible under subsections (1)(a) through (1)(d), an insurer may acquire rated credit instruments that are not foreign investments.

(2) An insurer may not acquire special rated credit instruments under this section if, as a result of and after giving effect to the investment, the aggregate amount of special rated credit instruments then held by the insurer would exceed 5% of its admitted assets.

History: En. Sec. 27, Ch. 304, L. 1999.

33-12-304. Insurer investment pools. (1) An insurer may acquire investments in investment pools that:

(a) invest only in:

(i) obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating by a nationally recognized statistical rating organization recognized by the SVO or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating and have:

(A) a remaining maturity of 397 days or less or a put option that entitles the holder to receive the principal amount of the obligation that may be exercised through maturity at specified intervals not exceeding 397 days; or

(B) a remaining maturity of 3 years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London interbank offered rate, or commercial paper) and is subject to no maximum limit if the obligations do not have an interest rate that varies inversely to market interest rate changes;

(ii) government money market mutual funds or class one money market mutual funds; or

(iii) securities lending, repurchase, and reverse repurchase transactions that meet all the requirements of 33-12-308, except the quantitative limitations of 33-12-308(1)(d); or

(b) invest only in investments that an insurer may acquire under this chapter if the insurer's proportionate interest in the amount invested in these investments does not exceed the applicable limits of this chapter.

(2) For an investment in an investment pool to be qualified under this chapter, the investment pool may not:

(a) acquire securities issued, assumed, insured, or guaranteed by the insurer or an affiliate of the insurer;

(b) borrow or incur any indebtedness for borrowed money, except for securities lending and reverse repurchase transactions that meet the requirements of 33-12-308, except the quantitative limitations of 33-12-308(1)(d); or

(c) permit the aggregate value of securities then loaned or sold to, purchased from, or invested in any one business entity under this section to exceed 10% of the total assets of the investment pool.

(3) The limitations of 33-12-302(1) do not apply to an insurer's investment in an investment pool. However, an insurer may not acquire an investment in an investment pool under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section:

(a) in any one investment pool would exceed 10% of its admitted assets;

(b) in all investment pools investing in investments permitted under subsection (1)(b) would exceed 25% of its admitted assets; or

(c) in all investment pools would exceed 40% of its admitted assets.

(4) For an investment in an investment pool to be qualified under this chapter, the manager of the investment pool:

(a) must be organized under the laws of the United States or a state and must be designated as the pool manager in a pooling agreement;

(b) must be:

(i) the insurer, an affiliated insurer, a business entity affiliated with the insurer, a qualified bank, or a business entity registered under the Investment Advisers Act of 1940 (15 U.S.C. 80b-1, et seq.), as amended;

(ii) in the case of a reciprocal insurer or interinsurance exchange, its attorney-in-fact; or

(iii) in the case of a United States branch of an alien insurer, its United States manager or affiliates or subsidiaries of its United States manager;

(c) shall compile and maintain detailed accounting records setting forth:

(i) the cash receipts and disbursements reflecting each participant's proportionate investment in the investment pool;

(ii) a complete description of all underlying assets of the investment pool, including amount, interest rate, maturity date, if any, and other appropriate designations; and

(iii) other records that, on a daily basis, allow third parties to verify each participant's investment in the investment pool; and

(d) shall maintain the assets of the investment pool in one or more accounts, in the name of or on behalf of the investment pool, under a custody agreement with a qualified bank. The custody agreement must:

(i) state and recognize the claims and rights of each participant;

(ii) acknowledge that the underlying assets of the investment pool are held solely for the benefit of each participant in proportion to the aggregate amount of its investments in the investment pool; and

(iii) contain an agreement that the underlying assets of the investment pool may not be commingled with the general assets of the custodian qualified bank or any other person.

(5) The pooling agreement for each investment pool must be in writing and must provide that:

(a) an insurer and its affiliated insurers or, in the case of an investment pool investing solely in investments permitted under subsection (1)(a), the insurer and its subsidiaries or affiliates, any pension or profit-sharing plan of the insurer or its subsidiaries and affiliates, or in the case of a United States branch of an alien insurer, the affiliates or subsidiaries of its United States manager shall, at all times, hold 100% of the interests in the investment pool;

(b) the underlying assets of the investment pool may not be commingled with the general assets of the pool manager or any other person;

(c) in proportion to the aggregate amount of each pool participant's interest in the investment pool:

(i) each participant owns an undivided interest in the underlying assets of the investment pool; and

(ii) the underlying assets of the investment pool are held solely for the benefit of each participant;

(d) a participant or, in the event of the participant's insolvency, bankruptcy, or receivership, its trustee, receiver, or other successor in interest may withdraw all or any portion of its investment from the investment pool under the terms of the pooling agreement;

(e) withdrawals may be made on demand without penalty or other assessment on any business day, but settlement of funds must occur within a reasonable and customary period after withdrawal not to exceed 5 business days. Distributions under this subsection (5)(e) must be calculated in each case net of all then-applicable fees and expenses of the investment pool. The pooling agreement must provide that the pool manager shall distribute to a participant, at the discretion of the pool manager:

(i) in cash, the then fair market value of the participant's pro rata share of each underlying asset of the investment pool;

(ii) in kind, a pro rata share of each underlying asset; or

(iii) in a combination of cash and in-kind distributions, a pro rata share in each underlying asset; and

(f) the pool manager shall make the records of the investment pool available for inspection by the commissioner.

History: **En. Sec. 28, Ch. 304, L. 1999.**

33-12-305. Equity interests. (1) Subject to the limitations of 33-12-302, an insurer may acquire equity interests in business entities organized under the laws of any domestic jurisdiction.

(2) An insurer may not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of investments then held by the insurer under this section would exceed the greater of 25% of its admitted assets or 100% of its surplus as regards policyholders.

(3) An insurer may not acquire under this section any investments that the insurer may acquire under 33-12-307.

(4) An insurer may not short sell equity investments unless the insurer covers the short sale by owning the equity investment or an unrestricted right to the equity instrument exercisable within 6 months of the short sale.

History: **En. Sec. 29, Ch. 304, L. 1999.**

33-12-306. Tangible personal property under lease. (1) (a) Subject to the limitations of 33-12-302, an insurer may acquire tangible personal property or equity interests in tangible personal property located or used wholly or in part within a domestic jurisdiction, either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by 33-12-104(4), joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments.

(b) Investments acquired under subsection (1)(a) are eligible only if:

(i) the property is subject to a lease or other agreement with a person whose rated credit instruments in the amount of the purchase price of the personal property the insurer could then acquire under 33-12-303; and

(ii) the lease or other agreement provides the insurer the right to receive rental, purchase, or other fixed payments for the use or purchase of the property and the aggregate value of the payments, together with the estimated residual value of the property at the end of its useful life and the estimated tax benefits to the insurer resulting from ownership of the property, are adequate to return the cost of the insurer's investment in the property, plus a return considered adequate by the insurer.

(2) The insurer shall compute the amount of each investment under this section on the basis of the out-of-pocket purchase price and applicable related expenses paid by the insurer for the investment, net of each borrowing made to finance the purchase price and expenses, to the extent the borrowing is without recourse to the insurer.

(3) An insurer may not acquire an investment under this section if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under this section would exceed:

(a) 2% of its admitted assets; or

(b) 0.5% of its admitted assets as to any single item of tangible personal property.

(4) For purposes of determining compliance with the limitations of 33-12-302, investments acquired by an insurer under this section must be aggregated with those acquired under 33-12-303 and each lessee of the property under a lease referred to in this section is considered the issuer of an obligation in the amount of the investment of the insurer in the property determined as provided in subsection (2).

(5) This section is not applicable to tangible personal property lease arrangements between an insurer and its subsidiaries and affiliates under a cost-sharing arrangement or agreement permitted under Title 33, chapter 2, part 11.

History: **En. Sec. 30, Ch. 304, L. 1999.**

33-12-307. Mortgage loans — income producing real estate — real estate for accommodation of business — quantitative limitations. (1) (a) Subject to the limitations of 33-12-302, an insurer may acquire obligations secured by mortgages on real estate situated within a domestic jurisdiction, either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by 33-12-104(4), joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments. However, a mortgage loan that is secured by other than a first lien may not be acquired unless the insurer is the holder of the first lien. The obligations held by the insurer and any obligations with an equal lien priority may not, at the time of acquisition of the obligation, exceed:

(i) 90% of the fair market value of the real estate if the mortgage loan is secured by a purchase money mortgage or similar security received by the insurer upon disposition of the real estate;

(ii) 80% of the fair market value of the real estate if the mortgage loan requires immediate scheduled payment in periodic installments of principal and interest, has an amortization period of 30 years or less, and has periodic payments made no less frequently than annually. Each periodic payment must be sufficient to ensure that at all times the outstanding principal balance of the mortgage loan is not greater than the outstanding principal balance that would be outstanding under a mortgage loan with the same original principal balance, with the same interest rate, and requiring equal payments of principal and interest with the same frequency over the same amortization period. Mortgage loans permitted under this subsection (1)(b) are permitted notwithstanding the fact that they provide for a payment of the principal balance prior to the end of the period of amortization of the loan. For residential mortgage loans, the 80% limitation may be increased to 97% if acceptable private mortgage insurance has been obtained.

(iii) 75% of the fair market value of the real estate for mortgage loans that do not meet the requirements of subsections (1)(a)(i) or (1)(a)(ii).

(b) For purposes of subsection (1)(a), the amount of an obligation required to be included in the calculation of the loan-to-value ratio may be reduced to the extent the obligation is insured by the federal housing administration, guaranteed by the administrator of veterans affairs, or insured or guaranteed by their successors.

(c) A mortgage loan that is held by an insurer under 33-12-103(6) or acquired under this section and that is restructured in a manner that meets the requirements of a restructured mortgage loan in accordance with the NAIC Accounting Practices and Procedures Manual or a successor publication continues to qualify as a mortgage loan under this chapter.

(d) Subject to the limitations of 33-12-302, credit lease transactions that do not qualify for investment under 33-12-303 and that have the following characteristics are exempt from the provisions of subsection (1)(a):

(i) the loan amortizes over the initial fixed lease term in at least an amount sufficient so that the loan balance at the end of the lease term does not exceed the original appraised value of the real estate;

(ii) the lease payments cover or exceed the total debt service over the life of the loan;

(iii) a tenant or its affiliated entity with rated credit instruments that have an SVO 1 or 2 designation or a comparable rating from a nationally recognized statistical rating organization recognized by the SVO has a full faith and credit obligation to make the lease payments;

(iv) the insurer holds or is the beneficial holder of a first lien mortgage on the real estate;

(v) the expenses of the real estate are passed through to the tenant, excluding exterior, structural, parking, and heating, ventilation, and air-conditioning replacement expenses, unless annual escrow contributions, from cash flows derived from the lease payments, cover the expense shortfall; and

(vi) there is a perfected assignment of the rents due pursuant to the lease to or for the benefit of the insurer.

(2) (a) An insurer may acquire, manage, and dispose of real estate situated in a domestic jurisdiction, either directly or indirectly through limited partnership interests and general partnership interests not otherwise prohibited by 33-12-104(4), joint ventures, stock of an investment subsidiary, membership interests in a limited liability company, trust certificates, or other similar instruments. The real estate must be income-producing or intended for improvement or development for investment purposes under an existing program, in which case the real estate must be considered to be income-producing.

(b) The real estate may be subject to mortgages, liens, or other encumbrances, the amount of which must, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsections (4)(b) and (4)(c).

(3) (a) An insurer may acquire, manage, and dispose of real estate for the convenient accommodation of the insurer's or the insurer's affiliates' business operations, including home office, branch office, and field office operations.

(b) Real estate acquired under this subsection (3) may include excess space for rent to others if the excess space, valued at its fair market value, would otherwise be a permitted investment under subsection (2) and is so qualified by the insurer.

(c) The real estate acquired under this subsection (3) may be subject to one or more mortgages, liens, or other encumbrances, the amount of which must, to the extent that the obligations secured by the mortgages, liens, or encumbrances are without recourse to the insurer, be deducted from the amount of the investment of the insurer in the real estate for purposes of determining compliance with subsection (4)(d).

(d) For purposes of this subsection (3), business operations may not include that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively. An insurer may acquire real estate used for these purposes under subsection (2).

(4) (a) An insurer may not acquire an investment under subsection (1) if, as a result of and after giving effect to the investment, the aggregate amount of all investments then held by the insurer under subsection (1) would exceed:

(i) 1% of its admitted assets in mortgage loans covering any one secured location;

(ii) 0.25% of its admitted assets in construction loans covering any one secured location; or

(iii) 1% of its admitted assets in construction loans in the aggregate.

(b) An insurer may not acquire an investment under subsection (2) if, as a result of and after giving effect to the investment and any outstanding guarantees made by the insurer in connection with the investment, the aggregate amount of investments then held by the insurer under subsection (2) plus the guarantees then outstanding would exceed:

(i) 1% of its admitted assets in any one parcel or group of contiguous parcels of real estate, except that this limitation does not apply to that portion of real estate used for the direct provision of health care services by an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively, such as hospitals, medical clinics, medical professional buildings, or other health facilities used for the purpose of providing health services; or

(ii) the lesser of 10% of its admitted assets or 40% of its surplus as regards policyholders in the aggregate, except for an insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least 95% of total premium considerations or total statutory required reserves, respectively. This limitation must be increased to 15% of its admitted assets in the aggregate.

(c) An insurer may not acquire an investment under subsection (1) or (2) if, as a result of and after giving effect to the investment and any outstanding guarantees it has made in connection with the investment, the aggregate amount of all investments then held by the insurer under subsection (1) or (2) plus the guarantees then outstanding would exceed 25% of its admitted assets.

(d) The limitations of 33-12-302 do not apply to an insurer's acquisition of real estate under subsection (3). An insurer may not acquire real estate under subsection (3) if, as a result of and after giving effect to the acquisition, the aggregate amount of all real estate then held by the insurer under subsection (3) would exceed 10% of its admitted assets. With the permission of the commissioner, additional amounts of real estate may be acquired under subsection (3).

History: **En. Sec. 31, Ch. 304, L. 1999.**

33-12-308. Securities lending, repurchase, reverse repurchase, and dollar roll transactions. (1) An insurer may enter into securities lending, repurchase, reverse repurchase, and dollar roll transactions with business entities, subject to the following requirements:

(a) The insurer's board of directors shall adopt a written plan that is consistent with the requirements of the written plan provided for in 33-12-104(1) that specifies guidelines and objectives to be followed, such as:

(i) a description of how cash received will be invested or used for general corporate purposes of the insurer;

(ii) operational procedures to manage interest rate risk, counterparty default risk, the conditions under which proceeds from reverse repurchase transactions may be used in the ordinary course of business, and the use of acceptable collateral in a manner that reflects the liquidity needs of the transaction; and

(iii) the extent to which the insurer may engage in these transactions.

(b) The insurer shall enter into a written agreement for all transactions authorized in this section other than dollar roll transactions. The written agreement must require that each transaction terminate no more than 1 year from its inception or upon the earlier demand of the insurer. The agreement must be with the business entity counterparty, but for securities lending transactions, the agreement may be with an agent acting on behalf of the insurer if the agent is a qualified business entity and if the agreement:

(i) requires the agent to enter into separate agreements with each counterparty that are consistent with the requirements of this section; and

(ii) prohibits securities lending transactions under the agreement with the agent or its affiliates.

(c) Cash received in a transaction under this section must be invested in accordance with this chapter and in a manner that recognizes the liquidity needs of the transaction or must be used by the insurer for its general corporate purposes. For as long as the transaction remains outstanding, the insurer or its agent or custodian shall maintain, as to acceptable collateral received in a transaction under this section, either physically or through the book-entry systems of the federal reserve, depository trust company, participants trust company, or other securities depositories approved by the commissioner:

(i) possession of the acceptable collateral;

(ii) a perfected security interest in the acceptable collateral; or

(iii) in the case of a jurisdiction outside of the United States, title to or rights of a secured creditor to the acceptable collateral.

(d) The limitations of 33-12-302 and 33-12-309 do not apply to the business entity counterparty exposure created by transactions under this section. For purposes of calculations made to determine compliance with this subsection (1), no effect will be given to the insurer's future obligation to resell securities, in the case of a repurchase transaction, or to repurchase securities, in the case of a reverse repurchase transaction. An insurer may not enter into a transaction under this section if, as a result of and after giving effect to the transaction:

(i) the aggregate amount of securities then loaned, sold to, or purchased from any one business entity counterparty under this section would exceed 5% of the insurer's admitted assets. In calculating the amount sold to or purchased from a business entity counterparty under repurchase or reverse repurchase transactions, effect may be given to netting provisions under a master written agreement.

(ii) the aggregate amount of all securities then loaned, sold to, or purchased from all business entities under this section would exceed 40% of its admitted assets. However, the limitation of this subsection (1)(d) does not apply to reverse repurchase transactions as long as the borrowing is used to meet operational liquidity requirements resulting from an officially declared catastrophe and is subject to a plan approved by the commissioner.

(e) In a securities lending transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 102% of the market value of the securities loaned by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than the market value of the loaned securities, the business entity counterparty must be obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least 102% of the market value of the loaned securities.

(f) In a reverse repurchase transaction, other than a dollar roll transaction, the insurer shall receive acceptable collateral having a market value as of the transaction date at least equal to 95% of the market value of the securities transferred by the insurer in the transaction as of that date. If at any time the market value of the acceptable collateral is less than 95% of the market value of the securities transferred, the business entity counterparty is obligated to deliver additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least 95% of the market value of the transferred securities.

(g) In a dollar roll transaction, the insurer must receive cash in an amount at least equal to the market value of the securities transferred by the insurer in the transaction as of the transaction date.

(h) In a repurchase transaction, the insurer must receive as acceptable collateral transferred securities having a market value at least equal to 102% of the purchase price paid by the insurer for the securities. If at any time the market value of the acceptable collateral is less than 100% of the purchase price paid by the insurer, the business entity counterparty must be obligated to provide additional acceptable collateral, the market value of which, together with the market value of all acceptable collateral then held in connection with the transaction, equals at least 102% of the purchase price. Securities acquired by an insurer in a repurchase transaction may not be sold in a reverse repurchase transaction, loaned in a securities lending transaction, or otherwise pledged.

(2) To constitute acceptable collateral for the purposes of this section, a letter of credit must have an expiration date beyond the term of the subject transaction.

History: **En. Sec. 32, Ch. 304, L. 1999.**

33-12-309. Foreign investments and foreign currency exposure. (1) Subject to the limitations of 33-12-302, an insurer may acquire foreign investments or engage in investment practices with persons of or in foreign jurisdictions if the investments or investment practices are of substantially the same types as those that an insurer is permitted to acquire under this chapter, other than of the type permitted under 33-12-304 and if as a result of and after giving effect to the investment the aggregate amount of foreign investments then held by the insurer under this subsection (1):

(a) does not exceed 20% of its admitted assets; and

(b) in a single foreign jurisdiction does not exceed 10% of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 5% of its admitted assets as to any other foreign jurisdiction.

(2) (a) Subject to the limitations of 33-12-302, an insurer may acquire investments or engage in investment practices denominated in foreign currencies, whether or not they are foreign investments acquired under subsection (1), or additional foreign currency exposure as a result of the termination or expiration of a hedging transaction with respect to investments denominated in a foreign currency if:

(i) the aggregate amount of investments then held by the insurer under this subsection (2) denominated in foreign currencies does not exceed 15% of its admitted assets; and

(ii) the aggregate amount of investments then held by the insurer under this subsection (2) denominated in the foreign currency of a single foreign jurisdiction does not exceed 10% of its admitted assets as to a foreign jurisdiction that has a sovereign debt rating of SVO 1 or 5% of its admitted assets as to any other foreign jurisdiction.

(b) However, an investment may not be considered denominated in a foreign currency if the acquiring insurer enters into one or more contracts in transactions permitted under 33-12-310 and the business entity counterparty agrees under the contract or contracts to exchange all payments made on the foreign currency denominated investment for United States currency at a rate that effectively insulates the investment cash flows against future changes in currency exchange rates during the period the contract or contracts are in effect.

(3) (a) Subject to 33-12-302 and subsection (3)(b) of this section and in addition to investments permitted under subsections (1) and (2), an insurer that is authorized to do business in a foreign jurisdiction and that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in that foreign jurisdiction and denominated in foreign currency of that jurisdiction may acquire foreign investments respecting that foreign jurisdiction and may acquire investments denominated in the currency of that jurisdiction.

(b) However, investments made under this subsection (3) in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises are not subject to the limitations of 33-12-302 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection (3) may not exceed the greater of:

(i) the amount the insurer is required by law to invest in the foreign jurisdiction; or

(ii) 125% of the amount of its reserves, net of reinsurance, and other obligations under the contracts.

(4) (a) In addition to investments permitted under subsections (1) and (2) and except as provided in subsection (4)(b), an insurer that is not authorized to do business in a foreign jurisdiction and that has outstanding insurance, annuity, or reinsurance contracts on lives or risks resident or located in a foreign jurisdiction and denominated in foreign currency of that jurisdiction may acquire foreign investments respecting that foreign jurisdiction and may acquire investments denominated in the currency of that jurisdiction subject to the limitations set forth in 33-12-302.

(b) However, investments made under this subsection (4) in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises are not subject to the limitations of 33-12-302 if those investments carry an SVO rating of 1 or 2. The aggregate amount of investments acquired by the insurer under this subsection (4) may not exceed 105% of the amount of its reserves, net of reinsurance, and other obligations under the contracts on risks resident or located in the foreign jurisdiction.

(5) Investments acquired under this section must be aggregated with investments of the same types made under this chapter and, in a similar manner, for purposes of determining compliance with the limitations, if any, contained in this chapter. Investments in obligations of foreign governments, their political subdivisions, and government-sponsored enterprises, except for those exempted under subsections (3) and (4), are subject to the limitations of 33-12-302.

History: En. Sec. 33, Ch. 304, L. 1999.

33-12-310. Derivative transactions. An insurer may, directly or indirectly through an investment subsidiary, engage in derivative transactions under this section under the following conditions:

(1) (a) An insurer may use derivative instruments under this section to engage in hedging transactions and certain income generation transactions as provided in rules adopted by the commissioner.

(b) An insurer must be able to demonstrate to the commissioner the intended hedging characteristics and the ongoing effectiveness of the derivative transaction or combination of transactions through cash flow testing or other appropriate analyses.

(2) An insurer may enter into hedging transactions under this section if, as a result of and after giving effect to the transaction:

(a) the aggregate statement value of options, caps, floors, and warrants not attached to another financial instrument purchased and used in hedging transactions does not exceed 5% of its admitted assets;

(b) the aggregate statement value of options, caps, and floors written in hedging transactions does not exceed 3% of its admitted assets; and

(c) the aggregate potential exposure of collars, swaps, forwards, and futures used in hedging transactions does not exceed 6.5% of its admitted assets.

(3) An insurer may enter into the following types of income-generation transactions only if, as a result of and after giving effect to the transactions, the aggregate statement value of the fixed-income assets that are subject to call, plus the face value of fixed-income securities underlying a derivative instrument subject to call, plus the amount of the purchase obligations under the put options does not exceed 10% of its admitted assets:

(a) sales of covered call options on noncallable, fixed-income securities, callable fixed-income securities if the option expires by its terms prior to the end of the noncallable period, or derivative instruments based on fixed-income securities;

(b) sales of covered call options on equity securities if the insurer holds in its portfolio or can immediately acquire, through the exercise of options, warrants, or conversion rights already owned, the equity securities subject to call during the complete term of the call option sold; or

(c) sales of covered put options on investments that the insurer is permitted to acquire under this chapter if the insurer has placed in escrow or entered into a custodian agreement segregating cash or cash equivalents with a market value equal to the amount of its purchase obligations under the put option during the complete term of the put option sold.

(4) An insurer shall include all counterparty exposure amounts in determining compliance with the limitations of 33-12-302.

(5) Pursuant to rules adopted under 33-12-111, the commissioner may approve additional transactions involving the use of derivative instruments in excess of the limits of subsection (2) or for other risk management purposes under rules adopted by the commissioner, but replication transactions may not be permitted for other than risk management purposes.

History: En. Sec. 34, Ch. 304, L. 1999.

33-12-311. Additional investment authority. (1) Under this section, an insurer may acquire investments, may engage in investment practices of any kind that are not specifically prohibited by this chapter, or may engage in investment practices without regard to any limitation in 33-12-302 through 33-12-309. However, an insurer may not acquire an investment or engage in an investment practice under this section if, as a result of and after giving effect to the transaction, the aggregate amount of the investments then held by the insurer under this section would exceed the greater of:

(a) its unrestricted surplus; or

(b) the lesser of:

(i) 10% of its admitted assets; or

(ii) 50% of its surplus as regards policyholders.

(2) An insurer may not acquire an investment or engage in an investment practice under subsection (1) if, as a result of and after giving effect to the transaction, the aggregate amount of all investments in any one person then held by the insurer under subsection (1) would exceed 5% of its admitted assets.

History: En. Sec. 35, Ch. 304, L. 1999.

33-12-312. Reserve requirements — authority of commissioner. (1) Subject to all other limitations and requirements of this title, a property and casualty, financial guaranty, mortgage guaranty, surety, marine, title, or accident and health insurer shall maintain an amount at least equal to 100% of adjusted loss reserves and loss adjustment expense reserves, 100% of adjusted unearned premium reserves, and 100% of statutorily required policy and contract reserves in:

(a) cash and cash equivalents;

(b) high-grade investments and medium-grade investments that qualify under 33-12-303 or 33-12-304;

(c) equity interests that qualify under 33-12-305 and that are traded on a qualified exchange;

(d) investments of the type set forth in 33-12-309 if the investments are rated in the highest generic rating category by a nationally recognized statistical rating organization recognized by the SVO for rating foreign jurisdictions and if any foreign currency exposure is effectively hedged through the maturity date of the investments;

(e) qualifying investments of the type set forth in subsection (1)(b), (1)(c), or (1)(d) that are acquired under 33-12-311;

(f) interest and dividends receivable on qualifying investments of the type set forth in subsections (1)(a) through (1)(e); or

(g) reinsurance recoverable on paid losses.

(2) (a) For purposes of determining the amount of assets to be maintained under this subsection (2), the calculation of adjusted loss reserves and loss adjustment expense reserves, adjusted unearned premium reserves, and statutorily required policy and contract reserves must be based on the amounts reported as of the most recent annual or quarterly statement date.

(b) Adjusted loss reserves and loss adjustment expense reserves must be equal to the sum of the amounts derived from the following calculations:

(i) the result of each amount reported by the insurer as losses and loss adjustment expenses unpaid for each accident year for each individual line of business; multiplied by

(ii) the discount factor that is applicable to the line of business and accident year published by the internal revenue service under Internal Revenue Code section 846 (26 U.S.C. 846), as amended, for the calendar year that corresponds to the most recent annual statement of the insurer; minus

(iii) accrued retrospective premiums discounted by an average discount factor. The discount factor must be calculated by dividing the losses and loss adjustment expenses unpaid after discounting (the product of subsections (2)(b)(i) and (2)(b)(ii)) by loss and loss adjustment expense reserves before discounting subsection (2)(b)(i).

(c) For purposes of the calculations in subsections (2)(b)(i) through (2)(b)(iii), the losses and loss adjustment expenses unpaid must be determined net of anticipated salvage and subrogation and gross of any discount for the time value of money or tabular discount.

(d) Adjusted unearned premium reserves must be equal to the result of the following calculation:

(i) the amount reported by the insurer as unearned premium reserves; minus

(ii) the admitted asset amounts reported by the insurer as:

(A) premiums in and agents' balances in the course of collection, accident and health premiums due and unpaid, and uncollected premiums for accident and health premiums;

(B) premiums, agents' balances, and installments booked but deferred and not yet due; and

(C) bills receivable, taken for premium.

(3) A property and casualty, financial guaranty, mortgage guaranty, surety, marine, title, or accident and health insurer shall supplement its annual statement with a reconciliation and summary of its assets and reserve requirements as required in (1). A reconciliation and summary showing that an insurer's assets as required in subsection (1) are greater than or equal to its undiscounted reserves referred to in subsection (1) must be sufficient to satisfy this requirement. Upon prior notification, the commissioner may require an insurer to submit a reconciliation and summary with any quarterly statement filed during the calendar year.

(4) If a property and casualty, financial guaranty, mortgage guaranty, surety, marine, title, or accident and health insurer's assets and reserves do not comply with subsection (1), the insurer shall notify the commissioner immediately of the amount by which the reserve requirements exceed the annual statement value of the qualifying assets, explain why the deficiency exists, and within 30 days of the date of the notice, propose a plan of action to remedy the deficiency.

(5) (a) If the commissioner determines that an insurer is not in compliance with subsection (1), the commissioner shall require the insurer to eliminate the condition causing the noncompliance within a specified time from the date the notice of the commissioner's requirement is mailed or delivered to the insurer.

(b) If an insurer fails to comply with the commissioner's requirement under subsection (5)(a), the insurer is considered to be in hazardous financial condition and the commissioner shall take one or more of the actions authorized by law with respect to insurers in hazardous financial condition.

History: **En. Sec. 36, Ch. 304, L. 1999.**

CHAPTER 13
RESERVED

CHAPTER 14
INSURANCE PREMIUM FINANCE COMPANIES

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Part 1
General Provisions

33-14-101. Short title. This chapter may be cited as the "Insurance Premium Finance Company Act".

History: En. Sec. 1, Ch. 360, L. 1981.

33-14-102. Definitions. As used in this chapter, the following definitions apply:

(1) "Insurance premium finance company" means a person engaged in the business of entering into premium finance agreements with insureds or of acquiring such premium finance agreements from insurance producers, brokers, or other premium finance companies.

(2) "Licensee" means a premium finance company holding a license issued by the commissioner under this chapter.

(3) "Premium finance agreement" means an agreement by which an insured or prospective insured promises to pay to a premium finance company the amount advanced or to be advanced under the agreement to an insurer or to an insurance producer or broker in payment of premiums on an insurance contract, together with a finance charge as authorized by this chapter, and as security therefor the insurance premium finance company receives an assignment of the unearned premium.

(4) "Unearned premium" means that part of the original premium, including a deposit, not yet earned by the insurer and therefore due the insured if a policy is canceled.

History: En. Sec. 2, Ch. 360, L. 1981; amd. Sec. 1, Ch. 123, L. 1987; amd. Sec. 1, Ch. 713, L. 1989.

Part 2
Licensing

33-14-201. License required — fee — renewal of license. (1) Except as provided in subsection (4), a person may not engage in the business of financing insurance premiums without first having obtained a license as a premium finance company from the commissioner. Any person who engages in the business of financing insurance premiums in the state without obtaining a license as provided under this chapter is, upon conviction, guilty of a misdemeanor.

(2) The annual license fee is $100. A license may be renewed as of January 1 each year, upon payment of the fee of $100. The license fee must be paid to the commissioner.

(3) The person to whom the license or the renewal of the license is issued shall file sworn answers, subject to the penalties of perjury, to any interrogatories as the commissioner may require. The commissioner may, at any time, require the applicant fully to disclose the identity of all stockholders, partners, officers, and employees, and the commissioner may, in the commissioner's discretion, refuse to issue or renew a license in the name of any firm, partnership, or corporation if not satisfied that any officer, employee, stockholder, or partner who may materially influence the applicant's conduct meets the standards of this chapter.

(4) This section does not apply to and a license is not required of:

(a) savings and loan associations, banks, trust companies, licensed finance companies, credit unions, and resident insurance producers; or

(b) a person who, within 15 days after entering into an insurance premium finance agreement, transfers the agreement to a licensee or to any of the organizations exempt under this subsection (4).

History: En. Sec. 3, Ch. 360, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 16, Ch. 451, L. 1993.

Cross-References

Banks and trust companies, Title 32, ch. 1.
Mutual savings and loan associations, Title 32, ch. 2.
Credit unions, Title 32, ch. 3.
Insurance producers, adjusters, consultants, and administrators, Title 33, ch. 17.

33-14-202. Applicant qualifications — hearing. (1) Upon the filing of an application and the payment of the license fee, the commissioner may make a background examination of each applicant and shall issue a premium finance company license if the applicant is qualified in accordance with this chapter. If the commissioner denies the application, the applicant may file a written demand for a hearing pursuant to the provisions of 33-1-701.

(2) The commissioner shall issue or renew a license when the commissioner is satisfied that the person to be licensed:

(a) is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

(b) has a good business reputation and has had experience, training, or education that qualifies the applicant in the business for which the license is applied; and

(c) if a corporation, is a corporation incorporated under the laws of the state or is a foreign corporation authorized to transact business in the state.

History: En. Sec. 4, Ch. 360, L. 1981; amd. Sec. 40, Ch. 227, L. 2001.

33-14-203. License revocation — suspension. The commissioner may revoke or suspend the license of a premium finance company when and if after investigation it appears to the commissioner that:

(1) a license issued to the company was obtained by fraud;

(2) there was misrepresentation in the application for the license;

(3) the holder of the license has otherwise been shown untrustworthy or incompetent to act as a premium finance company; or

(4) the company has violated any provisions of this chapter.

History: En. Sec. 5, Ch. 360, L. 1981; amd. Sec. 1180, Ch. 56, L. 2009.

33-14-204. Records required of licensees — form — inspection. (1) Every premium finance company shall maintain records of its premium finance transactions, and the records must be open to examination and investigation by the commissioner. The commissioner may at any time require the company to bring records that the commissioner may direct to the commissioner's office for examination.

(2) Every premium finance company shall preserve its records of premium finance transactions for at least 3 years after making the final entry in respect to any premium finance agreement. The records may be preserved in photographic form.

History: En. Sec. 6, Ch. 360, L. 1981; amd. Sec. 1181, Ch. 56, L. 2009.

Part 3
Operation and Regulation

33-14-301. Premium finance agreements — contents — form — delivery. (1) A premium finance agreement must:

(a) be dated and signed by the insured or by any person authorized in writing to act in behalf of the insured, and the printed portion of the agreement must be in at least 8-point type;

(b) contain the name and place of business of the insurance producer negotiating the related insurance policy, the name and residence or the place of business of the insured as specified by the insured, the name and place of business of the premium finance company to which payments are to be made, and a description of the insurance policies involved and the amount of the premium for the policies; and

(c) set forth when applicable:

(i) the total amount of the premiums;

(ii) the amount of the downpayment;

(iii) the principal balance, which is the difference between the items enumerated in subsections (1)(c)(i) and (1)(c)(ii);

(iv) the amount of the finance charge;

(v) the balance payable by the insured, which is the sum of the items enumerated in subsections (1)(c)(iii) and (1)(c)(iv); and

(vi) the number of installments required, the amount of each installment expressed in dollars, and the due date or period of the installments.

(2) The items set out in subsection (1)(c) are not required to be stated in the sequence or order in which they appear in that subsection, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(3) The information required by subsection (1) may be required in the initial agreement only if the premium finance company and the insured enter into an open-end credit transaction,

which is defined as a plan prescribing the terms of credit transactions that may be made under the plan from time to time and under the terms of which a finance charge may be computed on the outstanding unpaid balance from time to time under the plan.

(4) The premium finance company or the insurance producer shall deliver to the insured or mail to the insured at the address shown in the agreement a complete copy of the agreement.

History: En. Sec. 7, Ch. 360, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1182, Ch. 56, L. 2009.

33-14-302. Charges for premium financing regulated — method of computation. (1) A premium finance company may not charge, contract for, receive, or collect a finance charge other than as permitted by this chapter.

(2) The finance charge must be computed on the balance of the premiums due, after subtracting the downpayment made by the insured in accordance with the premium finance agreement, from the effective date of the insurance coverage for which the premiums are being advanced to and including the date when the final payment of the premium finance agreement is payable.

(3) Notwithstanding any other provision of law, the finance charge may not exceed interest at the annual rate of 21%, plus a service charge of $12.50 per premium finance agreement. The service charge of $12.50 is not required to be refunded upon cancellation or prepayment.

(4) An insured may prepay the premium finance agreement in full at any time prior to the due date of the final payment, and upon payment the unearned finance charge must be refunded.

History: En. Sec. 8, Ch. 360, L. 1981; amd. Sec. 1183, Ch. 56, L. 2009.

33-14-303. Delinquency charges regulated. (1) A premium finance agreement may provide for the payment by the insured of a delinquency charge of $1 to a maximum of 5% of the delinquent installment but not to exceed $5 on any installment that is in default for 5 days or more.

(2) If the default results in the cancellation of any insurance contract listed in the agreement, the agreement may provide for payment by the insured of a cancellation charge equal to the difference between any delinquency charge or default charge imposed with respect to the installment in default and $5. A premium finance agreement may also provide for the payment of attorney's fees and court costs if the agreement is referred for collection to an attorney not a salaried employee of the insurance premium finance company.

History: En. Sec. 9, Ch. 360, L. 1981.

33-14-304. Cancellation of insurance upon default. (1) When a premium finance agreement contains a power of attorney or other authority enabling the insurance premium finance company to cancel any insurance contract listed in the agreement, the insurance contract or contracts may not be canceled by the premium finance company unless the cancellation is effectuated in accordance with this section.

(2) Written notice must be mailed to the insured setting forth the intent of the insurance premium finance company to cancel the insurance contract unless the default is cured prior to the date stated in the notice. The written notice must be mailed at least 10 days prior to the date stated in the notice. The insurance producer indicated on the premium finance agreement must also be mailed 10 days' notice of this action.

(3) Pursuant to the power of attorney or other authority referred to above, the insurance premium finance company may cancel on behalf of the insured by mailing to the insurer written notice stating when the cancellation will become effective, and the insurance contract must be canceled as if the notice of cancellation had been submitted by the insured but without requiring the return of the insurance contract. If the insurer or its insurance producer does not provide the insurance premium finance company with a specific mailing address for the purpose of receipt of the notice, mailing by the insurance premium finance company to the insurer at the address that is on file with the commissioner is considered sufficient notice under this section. The insurance premium finance company shall also mail a notice of cancellation to the insured at the insured's last-known address and to the insurance producer indicated on the premium finance agreement.

(4) All statutory, regulatory, and contractual restrictions providing that the insurance contract may not be canceled unless notice is given to a governmental agency, mortgagee, or

other third party apply whenever cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice in behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation.

History: **En. Sec. 10, Ch. 360, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 44, Ch. 379, L. 1995.**

33-14-305. Return of unearned premiums. (1) Whenever a financed insurance contract is canceled by a person other than the insured, the insurer shall process cancellation of the financed insurance policy on a pro rata basis. The insurer shall return whatever gross unearned premiums are due under the insurance contract to the premium finance company for the account of the insured or insureds.

(2) If the crediting of the return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund the excess to the insured, except that a refund is not required if the excess amounts to less than $1.

History: **En. Sec. 11, Ch. 360, L. 1981; amd. Sec. 2, Ch. 123, L. 1987; amd. Sec. 17, Ch. 451, L. 1993.**

33-14-306. Agreement effective as security interest. No filing of the premium finance agreement or recording of a premium finance transaction shall be necessary to perfect the validity of the agreement as a secured transaction as against creditors, subsequent purchasers, pledgees, encumbrancers, successors, or assigns.

History: **En. Sec. 12, Ch. 360, L. 1981.**

Cross-References

U.C.C. — secured transactions, Title 30, ch. 9A.

33-14-307. Exceptions. This chapter does not apply to any insurance company or insurance companies affiliated under the same management and control authorized to do business in this state which provide installment premium payments programs at no interest to policyholders or to an insurance producer licensed to do business in this state on policies written by the insurance producer or issued by the company or companies.

History: **En. Sec. 13, Ch. 360, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.**

CHAPTER 15

THE INSURANCE CONTRACT

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33-15-1121. Unfair trade practices.
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Chapter Cross-References

Arbitration laws — nonapplicability, 27-5-114.
Contracts, Title 28, ch. 2.
Interpretation of contracts, Title 28, ch. 3.
Commissioner to approve policy forms, Title 33, ch. 1, part 5.
Unfair trade practices, Title 33, ch. 18.

Part 1
Scope and Definitions

33-15-101. Scope. Parts 1 through 5 do not apply as to:

(1) reinsurance;

(2) policies or contracts not issued for delivery in this state or delivered in this state;

(3) ocean marine and foreign trade insurances;

(4) title insurance, except as to the following provisions: 33-15-102, 33-15-103, 33-15-303, 33-15-305, 33-15-306, 33-15-307, 33-15-316, and 33-15-411.

History: En. Sec. 258, Ch. 286, L. 1959; R.C.M. 1947, 40-3701; amd. Sec. 17, Ch. 303, L. 1981.

Cross-References

Ocean marine insurance — definition, 33-1-209.
Title insurance — definition, 33-1-212.
Reinsurance — general provisions, Title 33, ch. 2, part 12.

33-15-102. Definitions. (1) "Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers attached thereto and a part thereof.

(2) "Premium" is the consideration for insurance, by whatever name called. Any assessment or membership, policy, survey, inspection, service, or similar fee or charge in consideration for an insurance contract is deemed part of the premium.

History: En. Secs. 259, 260, Ch. 286, L. 1959; R.C.M. 1947, 40-3702, 40-3703.

Cross-References

Premium — exception of placement fee — state compensation insurance fund, 33-18-212.

33-15-103. Power to contract — purchase of insurance by minors. (1) Any person of competent legal capacity may contract for insurance.

(2) Any minor 15 years of age or older, as determined by the nearest birthday, may contract for annuities and for insurance upon the minor's own life, body, health, property, liabilities, or other interests or on the person of another in whom the minor has an insurable interest. The minor must be considered competent to exercise all rights and powers with respect to or under any contract for annuity or for insurance upon the minor's own life, body, or health or any contract the minor effected upon the minor's own property, liabilities, or other interests or on the person of another as might be exercised by a person of full legal age and may at any time surrender the minor's interest in any contracts and give valid discharge for any benefit accruing or money payable under the contracts. The minor may not, by reason of minority, be entitled to rescind, avoid, or repudiate the contract or to rescind, avoid, or repudiate any exercise of a right or privilege under the contract, except that the minor, not otherwise emancipated, may not be bound by any unperformed agreement to pay by promissory note or otherwise any premium on any annuity or insurance contract.

(3) If any minor mentioned in subsection (2) is possessed of an estate that is being administered by a guardian, the contract is not binding upon the estate as to payment of premiums except when consented to by the guardian and approved by the district court of the county in which the administration of the estate is pending, and the consent and approval is required for each annual premium payment.

(4) Any annuity contract or policy of life or disability insurance procured by or for a minor under subsection (2) must be made payable either to the minor, to the minor's estate, or to a person having an insurable interest in the life of the minor under 33-15-201.

History: En. Sec. 267, Ch. 286, L. 1959; R.C.M. 1947, 40-3710; amd. Sec. 147, Ch. 575, L. 1981; amd. Sec. 1184, Ch. 56, L. 2009.

Cross-References

Legal capacity to contract, Title 28, ch. 2, part 2.
Minors — acquittance and discharge, 33-15-502.
Avoidance of contracts by minors, 41-1-304.

Part 2
Insurable Interests

33-15-201. Restrictions on contracting for personal insurance — insurable interests — violation. (1) Any individual of competent legal capacity may procure or effect an insurance contract upon the individual's own life or body for the benefit of any person. However, a person may not procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under the contract are payable to the individual insured, to the individual's personal representatives, or to a person having, at the time when the contract was made, an insurable interest in the individual insured.

(2) If the beneficiary, assignee, or other payee under any contract made in violation of this section receives from the insurer any benefits under the contract accruing upon the death, disablement, or injury of the individual insured, the individual insured or the individual's personal representative may maintain an action to recover the benefits from the person receiving them.

(3) "Insurable interest" with reference to personal insurance includes only interests as follows:

(a) in the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;

(b) in the case of other persons, a lawful and substantial economic interest in having the life, health, or bodily safety of the individual insured continue, as distinguished from an interest that would arise only by or would be enhanced in value by the death, disablement, or injury of the individual insured.

(4) An individual who is a party to a contract or option for the purchase or sale of an interest in a business partnership or firm or of shares of stock of a closed corporation or of an interest in the shares has an insurable interest in the life of each individual party to the contract and for the purposes of the contract only in addition to any insurable interest that may otherwise exist as to the life of the individual.

(5) A charitable institution has an insurable interest in an individual if:

(a) the individual authorizes the charitable institution to purchase insurance naming the charitable institution as an irrevocable beneficiary; and

(b) the insurance is purchased with contributions made by the individual.

History: En. Sec. 261, Ch. 286, L. 1959; R.C.M. 1947, 40-3704; amd. Sec. 148, Ch. 575, L. 1981; amd. Sec. 3, Ch. 670, L. 1991; amd. Sec. 1185, Ch. 56, L. 2009.

Cross-References

Legal capacity to contract, Title 28, ch. 2, part 2.

Homicide — effect on intestate succession, wills, trusts, joint assets, life insurance, and beneficiary designations, 72-2-813.

Personal representatives — actions by, 72-3-613.

Gift policies to minors, 72-26-603.

33-15-202 through 33-15-204 reserved.

33-15-205. Restrictions on property insurance — interest. (1) No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss.

(2) "Insurable interest" as used in this section means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment.

(3) The measure of an insurable interest in property is the extent to which the insured might be damnified by loss, injury, or impairment thereof.

History: En. Sec. 262, Ch. 286, L. 1959; R.C.M. 1947, 40-3705.

33-15-206. Interest of named insured — change of interest on death — transfer. (1) When the name of the person insured is specified in a policy insuring property, the insurance can be applied only to the person's own proper interest.

(2) A change of interest, by will or succession, on the death of the insured does not avoid an insurance of property, and the insurance passes to the person taking the insured's interest in

the thing insured. A change of interest in real property by a transfer on death deed on the death of the insured does not avoid an insurance of real property, and the real property insurance coverage continues beyond the death of the named insured in accordance with 72-6-412(5) and policy coverage, including all applicable terms and conditions.

(3) A transfer of interest by one of several partners, joint owners, or owners in common, who are jointly insured, to the others does not avoid an insurance of property even though it has been agreed that the insurance must cease upon an alienation of the thing insured.

History: En. Secs. 263, 264, 265, Ch. 286, L. 1959; R.C.M. 1947, 40-3706, 40-3707, 40-3708; amd. Sec. 1186, Ch. 56, L. 2009; amd. Sec. 1, Ch. 296, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 1, Ch. 296, L. 2025. Amendment effective May 1, 2025.

33-15-207. Insurance without interest or of wager — void. (1) Every stipulation in a policy of insurance of property for the payment of loss without regard to absence of an insurable interest in such property on the part of the insured or that the policy shall be received as proof of such interest is void.

(2) Every policy executed by way of gaming or wagering is void.

History: En. Sec. 266, Ch. 286, L. 1959; R.C.M. 1947, 40-3709.

Part 3
Policy Provisions

Part Cross-References

Unfair trade practices, Title 33, ch. 18.
Crop hail insurance, Title 80, ch. 2, part 2.

33-15-301. Requiring standard provisions — waiver. (1) Insurance contracts must contain the standard or uniform provisions and benefits required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The commissioner may waive a particular provision in a particular insurance policy form if:

(a) the commissioner finds the provision or benefit unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and

(b) the policy is otherwise approved by the commissioner.

(2) A policy or certificate may not contain any provision or benefit inconsistent with or contradictory to any standard or uniform provision or benefit used or required to be used, but the commissioner may approve any substitute provision or benefit that is, in the commissioner's opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(3) In lieu of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the commissioner.

(4) A provision, if required to be contained in the policy, may not be waived by agreement between the insurer and any other person.

History: En. Sec. 273, Ch. 286, L. 1959; R.C.M. 1947, 40-3716; amd. Sec. 45, Ch. 379, L. 1995.

Cross-References

Approval of forms, Title 33, ch. 1, part 5.
Hearings by Commissioner, 33-1-701.

33-15-302. Policy must contain entire contract. The policy, when issued, shall contain the entire contract between the parties, and neither the insurer or any insurance producer or representative thereof nor any person insured thereunder shall make any agreement as to the insurance which is not plainly expressed in the policy. This provision shall not be deemed to prohibit the modification of a policy, after issuance, by written rider or endorsement duly issued by the insurer.

History: En. Sec. 274, Ch. 286, L. 1959; R.C.M. 1947, 40-3717; amd. Sec. 1, Ch. 713, L. 1989.

Cross-References

When several contracts taken together, 28-3-203.

33-15-303. Contents of policies in general — identification. (1) Each policy must specify:

(a) the names of the parties to the contract;

(b) the subject of the insurance;
(c) the risks insured against;
(d) the time when the insurance under the policy takes effect and the period during which the insurance is to continue;
(e) the premium;
(f) the conditions pertaining to the insurance.

(2) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid must be included.

(3) All policies and annuity contracts issued by insurers and the forms of policies and annuity contracts filed with the commissioner must have printed on the policy or annuity contract an appropriate designating letter or figure, combination of letters or figures, or terms identifying the respective forms of policies or contracts. Each form, including riders and endorsements, must be identified by a designating letter or figure placed in a lower, preferably left-hand, corner of the first page of the form. Whenever any change is made in any form, the designating letters, figures, or terms on the form must be correspondingly changed and the revision date must be noted next to the designating letters.

History: **En. Sec. 275, Ch. 286, L. 1959; R.C.M. 1947, 40-3718; amd. Sec. 18, Ch. 303, L. 1981; amd. Sec. 18, Ch. 451, L. 1993; amd. Sec. 46, Ch. 379, L. 1995.**

Cross-References

Group insurance, Title 33, ch. 20, parts 10 through 12; Title 33, ch. 22, part 5.
Surety insurance, Title 33, ch. 26.

33-15-304. Permissible content. A policy may contain additional provisions not inconsistent with this code and which are:

(1) required to be inserted by the laws of the insurer's domicile;
(2) necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract; or
(3) desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein.

History: **En. Sec. 276, Ch. 286, L. 1959; R.C.M. 1947, 40-3719.**

33-15-305. Prohibited content — charter or bylaws. No policy shall contain any provision purporting to make any portion of the charter, bylaws, or other constituent document of the insurer, other than the subscribers' agreement or power of attorney of a reciprocal insurer, a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid.

History: **En. Sec. 277, Ch. 286, L. 1959; R.C.M. 1947, 40-3720.**

Cross-References

Contracts — illegal objects and provisions, Title 28, ch. 2, part 7.
Power of attorney — reciprocal insurer, 33-5-301.

33-15-306. Execution of policies — facsimile signature. (1) Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer.

(2) A facsimile signature of any such executing individual may be used in lieu of an original signature.

(3) No insurance contract heretofore or hereafter issued and which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized so to execute as of the date of the policy.

History: **En. Sec. 278, Ch. 286, L. 1959; R.C.M. 1947, 40-3721.**

33-15-307. Underwriters' and combination policies. (1) Two or more authorized insurers may jointly issue and shall be jointly and severally liable on an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department, and such policy shall plainly show the true name of the insurer.

(2) Two or more insurers may, with the approval of the commissioner, issue a combination policy which shall contain provisions substantially as follows:

(a) that the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy; and

(b) that service of process or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers.

(3) This section shall not apply to cosurety obligations.

History: **En. Sec. 279, Ch. 286, Ch. 1959; R.C.M. 1947, 40-3722.**

33-15-308. Explanation of charges. An insurer, health service corporation, or health maintenance organization that issues policies, certificates, membership contracts, or subscriber contracts for delivery in this state on or after January 1, 2000, and that limits payment of health care services based on standards described as usual and customary, reasonable and customary, prevailing fee, allowable charges, a relative value schedule, or other comparable terms shall include, displayed in the schedule page or elsewhere in the policy, certificate, membership contract, or subscriber contract:

(1) a definition of the term or terms and an explanation of how the limitation of payment based on the term or terms is derived;

(2) if the standard of the term or terms is derived by the use of a database, a description of the database reasonably calculated to inform the insured or certificate holder of the method used to define the geographic or demographic area from which the data used to determine the term or terms is derived; and

(3) a statement informing the insured that the insured's health care provider may charge more than the limits established by the defined terms and that the additional charges may not be covered by the policy, certificate, membership contract, or subscriber contract.

History: **En. Sec. 1, Ch. 173, L. 1995; amd. Sec. 1, Ch. 134, L. 1999.**

33-15-309 through 33-15-314 reserved.

33-15-315. Validity of noncomplying forms. Any insurance policy, rider, or endorsement hereafter issued and otherwise valid which contains any condition or provision not in compliance with the requirements of this code shall not be thereby rendered invalid but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this code.

History: **En. Sec. 281, Ch. 286, L. 1959; R.C.M. 1947, 40-3724.**

33-15-316. Construction of policies. Every insurance contract shall be construed according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application which is a part of the policy.

History: **En. Sec. 282, Ch. 286, L. 1959; R.C.M. 1947, 40-3725.**

33-15-317. Insurance coverage of punitive damages. (1) Insurance coverage does not extend to punitive or exemplary damages unless expressly included by the contract of insurance.

(2) Prior to renewal of any policy in effect on October 1, 1987, the insurer shall provide the insured with notice of nonrenewal of coverage of punitive or exemplary damages in the same manner as required by the commissioner of insurance for the renewal of policies with altered terms.

History: **En. Sec. 3, Ch. 627, L. 1987.**

Cross-References

Punitive damages — when allowed, 27-1-220.
Punitive damages — liability — proof — award, 27-1-221.

33-15-318. Safety program requirement in workers' compensation policies. A policy, contract, or agreement to insure an employer against a workers' compensation or occupational disease risk must require each insured employer to implement a safety program, as provided in 39-71-1507, as part of the policy, contract, or agreement to provide workers' compensation or occupational disease insurance coverage.

History: **En. Sec. 11, Ch. 295, L. 1993.**

33-15-319 and 33-15-320 reserved.

33-15-321. Life and disability insurance policy language simplification. Sections 33-15-321 through 33-15-329 may be cited as the "Life and Disability Insurance Policy Language Simplification Act".

History: En. Sec. 1, Ch. 302, L. 1981.

Cross-References

Plain Language in Contracts Act, Title 30, ch. 14, part 11.

33-15-322. Purpose. (1) The purpose of 33-15-321 through 33-15-329 is to establish minimum standards for language used in policies, contracts, and certificates of life, disability, credit life, and credit disability insurance delivered or issued for delivery in this state to facilitate ease of reading by insureds.

(2) Sections 33-15-321 through 33-15-329 are not intended to increase the risk assumed by insurance companies or other entities subject to 33-15-321 through 33-15-329 or to supersede their obligation to comply with the substance of other insurance legislation applicable to life, disability, credit life, or credit disability insurance policies. Sections 33-15-321 through 33-15-329 are not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content.

History: En. Sec. 2, Ch. 302, L. 1981.

33-15-323. Definitions. As used in 33-15-321 through 33-15-329, the following definitions apply:

(1) "Company" or "insurer" means any life or disability insurance company, fraternal benefit society, nonprofit health service corporation, nonprofit hospital service corporation, nonprofit medical service corporation, prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar types of organizations.

(2) "Policy" or "policy form" means any:

(a) policy, contract, plan, or agreement of life or disability insurance, including credit life and credit disability insurance, delivered or issued for delivery in this state by any company subject to 33-15-321 through 33-15-329;

(b) certificate, contract, or policy issued by a fraternal benefit society; and

(c) certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state.

History: En. Sec. 3, Ch. 302, L. 1981.

33-15-324. Application — exceptions. (1) Sections 33-15-321 through 33-15-329 apply to all policies delivered or issued for delivery in this state by any company on or after the date such forms must be approved under 33-15-321 through 33-15-329, but nothing in 33-15-321 through 33-15-329 applies to:

(a) a policy which is a security subject to federal jurisdiction;

(b) a group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit disability insurance policy, but a certificate issued pursuant to a group policy delivered or issued for delivery in this state is not exempt;

(c) a group annuity contract which serves as a funding vehicle for pension, profit-sharing, or deferred compensation plans;

(d) a form used in connection with, as a conversion from, as an addition to, or in exchange pursuant to a contractual provision for a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the dates such forms must be approved under 33-15-321 through 33-15-329; or

(e) the renewal of a policy delivered or issued for delivery prior to the dates such forms must be approved under 33-15-321 through 33-15-329.

(2) Sections 33-15-321 through 33-15-329 provide the exclusive manner for determining language simplification standards for any policy forms.

(3) A non-English language policy delivered or issued for delivery in this state is in compliance with 33-15-325(1)(a) if the insurer certifies that the policy is translated from an English language policy which complies with 33-15-325(1)(a).

History: En. Sec. 4, Ch. 302, L. 1981.

33-15-325. Minimum policy language simplification standards. (1) In addition to any other requirements of law, no policy form, except as stated in 33-15-324, may be delivered or issued for delivery in this state on or after the date such form must be approved under 33-15-321 through 33-15-329, unless:

(a) the text achieves a minimum score of 40 on the Flesch reading ease test or an equivalent score on any other comparable test as provided in subsection (3);

(b) it is printed, except for specification pages, schedules, and tables, in not less than 10-point type, 1-point leaded;

(c) the style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text of the policy or to any endorsements or riders; and

(d) it contains a table of contents or an index of the principal sections of the policy if the policy has more than 3,000 words printed on three or fewer pages of text, or if the policy has more than three pages regardless of the number of words.

(2) For the purposes of this section, a Flesch reading ease test score is measured by the following method:

(a) For policy forms containing 10,000 words or less of text, the entire form is analyzed. For policy forms containing more than 10,000 words, the readability of two 200-word samples per page may be analyzed instead of the entire form. The samples must be separated by at least 20 printed lines.

(b) The number of words and sentences in the text is counted and the total number of words is divided by the total number of sentences. The figure obtained is multiplied by a factor of 1.015.

(c) The total number of syllables is counted and divided by the total number of words. The figure obtained is multiplied by a factor of 84.6.

(d) The sum of the figures computed under subsections (2)(b) and (2)(c) subtracted from 206.835 equals the Flesch reading ease score for the policy form.

(e) For the purposes of subsections (2)(b) through (2)(d), the following procedures are used:

(i) a contraction, hyphenated word, or numbers and letters, if separated by spaces, are counted as one word;

(ii) a unit of words ending with a period, semicolon, or colon, but excluding headings and captions, is counted as a sentence; and

(iii) a syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(f) The term "text" as used in this section includes all printed matter except the following:

(i) the name and address of the insurer; the name, number, or title of the policy; the table of contents or index; captions and subcaptions; specification pages, schedules, or tables; and

(ii) policy language which is drafted to conform to the requirements of a federal law, regulation, or agency interpretation; policy language required by a collectively bargained agreement; medical terminology; words which are defined in the policy; and policy language required by law or regulation. The insurer must identify the language or terminology excepted by this subsection and certify in writing that the language or terminology is entitled to be excepted by this subsection.

(3) Any other reading test may be approved by the commissioner for use as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(4) Filings subject to this section must be accompanied by a certificate signed by an officer of the insurer stating that it meets the minimum reading ease score on the test used or stating that the score is lower than the minimum required but should be approved in accordance with 33-15-327. To confirm the accuracy of any certification, the commissioner may require the submission of further information to verify the certification in question.

(5) At the option of the insurer, riders, endorsements, applications, and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

History: En. Sec. 5, Ch. 302, L. 1981.

33-15-326. Construction — time period. Nothing in 33-15-321 through 33-15-329 may be construed to negate any law of this state permitting the issuance of any policy form after it has been on file for the time period specified.

History: En. Sec. 6, Ch. 302, L. 1981.

33-15-327. Powers of the commissioner. The commissioner may authorize a lower score than the Flesch reading ease score required in 33-15-325(1)(a) whenever, in in the commissioner's sole discretion, the commissioner finds that a lower score:

(1) will provide a more accurate reflection of the readability of a policy form;

(2) is warranted by the nature of a particular policy form or type or class of policy forms; or

(3) is caused by certain policy language that is drafted to conform to the requirements of any state law, regulation, or agency interpretation.

History: En. Sec. 7, Ch. 302, L. 1981; amd. Sec. 1187, Ch. 56, L. 2009.

33-15-328. Approval of forms. A policy form meeting the requirements of 33-15-325(1)(a) may be approved by the commissioner notwithstanding the provisions of other laws that specify content of policies if the approved policy form provides policyholders and claimants protection not less favorable than they would be entitled to under such laws.

History: En. Sec. 8, Ch. 302, L. 1981.

33-15-329. Applicability schedule. (1) Except as provided in 33-15-324, the provisions of 33-15-321 through 33-15-329 apply to all policy forms filed on or after July 1, 1983. A policy form may not be delivered or issued for delivery in this state on or after July 1, 1986, unless approved by the commissioner or permitted to be issued under 33-15-321 through 33-15-329. Any policy form that has been approved or permitted to be issued prior to July 1, 1986, and that meets the standards set by 33-15-321 through 33-15-329 is not required to be refiled for approval but may continue to be lawfully delivered or issued for delivery in this state upon the filing with the commissioner of a list of the forms identified by form number and accompanied by a certificate as to each form in the manner provided in 33-15-325(4).

(2) The commissioner may extend the dates in subsection (1).

History: En. Sec. 10, Ch. 302, L. 1981; amd. Sec. 1188, Ch. 56, L. 2009.

33-15-330 through 33-15-332 reserved.

33-15-333. Short title. Sections 33-15-333 through 33-15-340 may be cited as the "Property and Casualty Insurance Policy Language Simplification Act".

History: En. Sec. 1, Ch. 416, L. 1993.

33-15-334. Purpose. (1) The purpose of 33-15-333 through 33-15-340 is to establish minimum language and format standards to make property and casualty policies easier to read.

(2) Sections 33-15-333 through 33-15-340 are not intended to increase the risk assumed under policies subject to 33-15-333 through 33-15-340. Sections 33-15-333 through 33-15-340 are not intended to impede flexibility and innovation in the development of policy forms or content. Sections 33-15-333 through 33-15-340 do not grant authority to the commissioner to mandate the standardization of policy forms or content.

History: En. Sec. 2, Ch. 416, L. 1993.

33-15-335. Definitions. As used in 33-15-333 through 33-15-340, the following definitions apply:

(1) "Casualty insurance" does not include accident and health or disability insurance.

(2) "Policy" or "policy form" means any written contract of property or casualty insurance delivered or issued for delivery in this state by or on behalf of any insurer licensed in this state.

History: En. Sec. 3, Ch. 416, L. 1993.

33-15-336. Applicability. (1) Other statutes of this state setting simplification standards for language or format do not apply to property and casualty policies.

(2) Sections 33-15-333 through 33-15-340 do not apply to policies in manuscript form or to the following kinds of insurance:

(a) ocean marine;

(b) surety and financial institution bonds;

(c) reinsurance; or

(d) commercial lines policies, including but not limited to commercial aviation.

(3) A non-English policy is considered in compliance with 33-15-337 if it was translated from an English policy that complies with 33-15-337.

History: En. Sec. 4, Ch. 416, L. 1993; amd. Sec. 25, Ch. 472, L. 1999; amd. Sec. 16, Ch. 157, L. 2023.

33-15-337. Minimum policy simplification standards. (1) All property and casualty policies subject to 33-15-333 through 33-15-340 must take into consideration the following factors:

(a) use of simple sentence structure, short sentences, and personal style;

(b) use of commonly understood words and everyday conversational language consistent with the policy's standing as a contract;

(c) avoidance of use of technical and legal terms and words with special meanings whenever possible;

(d) minimal reference to other sections or provisions of the policy;

(e) logical organization of text; and

(f) legibility.

(2) The policy must include a table of contents and notice section of important provisions.

(3) Each section must be self-contained and independent. However, general provisions applicable to more than one section may be included in a common section.

(4) The policy, except for declarations pages, schedules, and tables, must be printed in not less than 10-point type, 1-point leaded.

(5) The policy must be printed in a legible type style, with adequate contrast between ink and paper. Captions, headings, and spacings must be used to increase overall legibility.

(6) Policy exclusions may use technical terms, terms with special meanings, and court-interpreted terms to ensure policy clarity.

(7) Technical terms and words with special meanings must be avoided whenever possible.

(8) The policy text must achieve a minimum score of 40 on the Flesch reading ease test, an equivalent score on a comparable test, or a lower score on either if the commissioner finds the policy reasonably easy to read. For purposes of this section, a Flesch reading ease test must be scored by the following method:

(a) For a policy containing 10,000 words or less, the entire policy must be analyzed. For a policy containing more than 10,000 words, the readability of two 100-word samples per page may be analyzed instead. The samples must be separated by at least 20 printed lines.

(b) The total number of words in the text or sample must be divided by the total number of sentences. The figure obtained must be multiplied by 1.015.

(c) The total number of syllables in the text or sample must be divided by the total number of words. The figure obtained must be multiplied by 84.6.

(d) The sum of the figures computed under subsections (8)(b) and (8)(c) subtracted from 206.835 equals the Flesch reading ease test score.

(9) (a) For purposes of subsection (8), the following procedures must be used:

(i) A contraction, hyphenated word, number, and letter, when separated by spaces, are counted as one word.

(ii) A unit of text ending with a period, semicolon, or colon is counted as a sentence.

(iii) A syllable means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. When the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(iv) At the option of the insurer, a form made a part of the policy may be scored separately or as part of the policy.

(b) The term "text", as used in this section, includes all printed matter except:

(i) the name and address of the insurer;

(ii) the name, number, or title of the policy or form;

(iii) the table of contents or index;

(iv) headings and captions; and

(v) declarations pages, schedules, or tables.

History: En. Sec. 5, Ch. 416, L. 1993.

33-15-338. Powers of commissioner. (1) At the commissioner's discretion, the commissioner may extend any dates under 33-15-333 through 33-15-340.

(2) The commissioner has sole authority to enforce the provisions of 33-15-333 through 33-15-340 or to seek remedies for its violation.

(3) The commissioner may authorize a lower score than the Flesch reading ease score required in 33-15-337 when, in the commissioner's discretion, a lower score:

(a) will provide a more accurate reflection of the readability of a policy;

(b) is warranted by the nature of a particular policy or type or class of policy; or

(c) is caused by certain policy language that is drafted to conform to the requirements of any state law, regulation, or agency interpretation.

History: **En. Sec. 6, Ch. 416, L. 1993.**

33-15-339. Compliance with other statutorily required language. The requirements of any other laws that specify the language or content of a policy may be met by a policy complying with the provisions of 33-15-337. However, the policy must provide protection that, considered as a whole, is not less favorable to the insured than is required by the other laws.

History: **En. Sec. 7, Ch. 416, L. 1993.**

33-15-340. Liability and coverage not imputed. The existence or nonexistence of coverage or liability under a policy may not be construed from policy approval by the commissioner.

History: **En. Sec. 8, Ch. 416, L. 1993.**

Part 4
Application, Issuance, Renewal, Assignment, and Return

33-15-401. Application required — life and disability insurance. No life or disability insurance contract upon an individual, except a contract of group life insurance or of group or blanket disability insurance, shall be made or effectuated unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

(1) A spouse may effectuate such insurance upon the other spouse.

(2) Any person having an insurable interest in the life of a minor or any person upon whom a minor is dependent for support and maintenance may effectuate insurance upon the life of or pertaining to such minor.

(3) Family policies insuring any two or more members of a family may be issued on an application signed by either parent, a stepparent, or by a husband or wife.

History: **En. Sec. 268, Ch. 286, L. 1959; R.C.M. 1947, 40-3711.**

Cross-References

Legal capacity to contract, Title 28, ch. 2, part 2.

33-15-402. Application as evidence — copy to insured — alteration. (1) An application for the issuance of any life or disability insurance policy or annuity contract may not be admissible in evidence in any action relative to the policy or contract unless a true copy of the application was attached to or otherwise made a part of the policy or contract when issued. This provision does not apply to industrial life insurance policies.

(2) If any policy of life or disability insurance delivered in this state is reinstated or renewed and the insured or the beneficiary or assignee of the policy makes written request to the insurer for a copy of the application, if any, for reinstatement or renewal, the insurer shall, within 30 days after receipt of the request at its home office or at any of its branch offices, deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed after having been requested, the insurer is precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal. In the case of a request from a beneficiary, the time within which the insurer is required to furnish a copy of the application may not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's vested interest in the policy or contract.

(3) As to kinds of insurance other than life or disability insurance, an application for insurance signed by or on behalf of the insured may not be admissible in evidence in any action between the insured and the insurer arising out of the policy applied for if the insurer has failed, at expiration of 30 days after receipt by the insurer of written demand by or on behalf of the insured, to furnish to the insured a copy of the application reproduced by any legible means.

(4) An alteration of any written application for any life or disability insurance policy may not be made by any person other than the applicant without the applicant's written consent, except that insertions may be made by the insurer, for administrative purposes only, in a manner that clearly indicates that the insertions are not to be ascribed to the applicant.

History: En. Sec. 269, Ch. 286, L. 1959; R.C.M. 1947, 40-3712; amd. Sec. 1189, Ch. 56, L. 2009.

Cross-References

Industrial life insurance defined, 33-20-102.

33-15-403. Representations in applications — benefit precluded and rescission allowed if fraudulent or material. (1) All statements and descriptions in any application for an insurance policy or annuity contract or in negotiations for an insurance policy or annuity contract by or on behalf of the insured or annuitant are considered representations and not warranties.

(2) Misrepresentations, omissions, concealment of facts, and incorrect statements preclude a benefit and allow rescission under the policy or contract if:

(a) the representations are fraudulent;

(b) the representations are material either to the acceptance of the risk or to the hazard assumed by the insurer; or

(c) the insurer in good faith would either not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise; and

(d) the questions in the application are sufficiently specific so that a reasonable person would understand the requirement to provide the particular facts and that the applicant's response was material to the insurer's decision to provide coverage or to determine the premium or rate to be charged for the coverage.

(3) Subsection (2)(c) does not apply to nonrenewal or discontinuation of group health insurance offered in connection with a group health plan in the small group market or large group market, as those terms are defined in 33-22-140.

(4) If the parties to an insurance policy disagree regarding the propriety of rescission of a policy or a contract under this section, the district courts of this state have jurisdiction to determine the relative rights of the parties under the Uniform Declaratory Judgments Act in Title 27, chapter 8.

(5) This section may not be construed to limit or impair the powers and authority of the commissioner under this title.

History: En. Sec. 270, Ch. 286, L. 1959; R.C.M. 1947, 40-3713; amd. Sec. 1, Ch. 416, L. 1997; amd. Sec. 1, Ch. 315, L. 2019.

Cross-References

Fraud, misrepresentation, or mistake — contract rules, Title 28, ch. 2, part 4.

33-15-404 through 33-15-410 reserved.

33-15-411. Binders for temporary insurance. (1) Binders or other contracts for temporary insurance may be made orally or in writing and shall be deemed to include all the usual terms of the policy as to which the binder was given, together with such applicable endorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

(2) No binder shall be valid beyond the issuance of the policy with respect to which it was given or beyond 90 days from its effective date, whichever period is the shorter.

(3) If the policy has not been issued, a binder may be extended or renewed beyond such 90 days with the written approval of the insurer.

(4) This section shall not apply to life or disability insurance.

History: En. Sec. 283, Ch. 286, L. 1959; R.C.M. 1947, 40-3726.

33-15-412. Delivery of policy. (1) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled thereto within a reasonable period of time after its issuance, except where a condition required by the insurer has not been met by the insured.

(2) In event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle or aircraft and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle or aircraft is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle or aircraft, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy or memorandum thereof containing the same such information shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of such duplicate policy or memorandum.

History: En. Sec. 284, Ch. 286, L. 1959; R.C.M. 1947, 40-3727.

33-15-413. Renewal by certificate. Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable may be renewed or extended at the option of the insurer and upon a currently authorized policy form and at the premium rate then required therefor, for a specific additional period or periods by certificate or by endorsement of the policy, and without requiring the issuance of a new policy.

History: En. Sec. 285, Ch. 286, L. 1959; R.C.M. 1947, 40-3728.

33-15-414. Assignment. (1) A policy or group certificate issued under a policy may be assignable or not assignable, as provided by its terms.

(2) Subject to its terms relating to the assignability, any life or disability policy or group certificate under either, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or by transfer of title, by an assignment executed by the insured or owner, alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer.

(3) An assignment valid under this section may transfer to the assignee all the rights, privileges, and incidents of ownership of the assignor in the policy or group certificate, including but not limited to the rights to designate beneficiaries and of a group certificate holder to have an individual policy issued in accordance with 33-20-1209 and 33-20-1210. Any assignment entitles the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment until the insurer has received at its home office written notice of termination of the assignment or pledge or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment. However, the insurer may not be prejudiced by any payment made or action taken inconsistent with the terms of any assignment before the insurer has received and had reasonable time to act on written notice of the assignment.

(4) This section acknowledges, declares, and codifies the existing right of assignment of interests under insurance policies. An assignment otherwise valid is not invalid because it was made prior to July 1, 1971.

(5) An insurance producer may not have an ownership interest in any policy, by assignment or otherwise, unless the insurance producer has an insurable interest, as defined in 33-15-201, in the life of the insured, except with permission of the commissioner.

History: En. Sec. 286, Ch. 286, L. 1959; amd. Sec. 1, Ch. 167, L. 1971; R.C.M. 1947, 40-3729; amd. Sec. 41, Ch. 227, L. 2001.

33-15-415. Notice of right to return policy. Each individual life or disability insurance policy, except a single-premium nonrenewable disability policy, issued for delivery in this state or issued after January 1, 1996, must contain a notice stating in substance that if the person to whom the policy is issued is not satisfied for any reason, the person may return the policy within 10 days of its delivery or a longer period if provided by the policy and have refunded directly to the person the premium paid. A policy returned pursuant to this section is void from the beginning.

History: En. Sec. 75, Ch. 379, L. 1995.

33-15-416. Dating of insurance applications — antedating prohibited. An application for issuance of an insurance policy may not be antedated by any person in order to obtain or provide coverage for losses or injuries incurred prior to the date of application.

History: En. Sec. 77, Ch. 379, L. 1995.

Part 5
Claims and Benefits

33-15-501. Payment discharges insurer — notice to contrary. Whenever the proceeds of or payments under a life or disability insurance policy or annuity contract heretofore or hereafter issued become payable in accordance with the terms of such policy or contract or the exercise of any right or privilege thereunder and the insurer makes payment thereof in accordance with the terms of the policy or contract or in accordance with any written assignment thereof, the person then designated in the policy or contract or by such assignment as being entitled thereto shall be entitled to receive such proceeds or payments and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such payment or some interest in the policy or contract.

History: **En. Sec. 287, Ch. 286, L. 1959; R.C.M. 1947, 40-3730.**

Cross-References

Extinction of contractual obligation by performance, Title 28, ch. 1, part 11.

Destruction of property to defraud insurer — crime, 45-6-101.

33-15-502. Minor may give acquittance. (1) Any minor domiciled in this state who has attained the age of 16 years shall be deemed competent to receive and to give full acquittance and discharge for a payment or payments in aggregate amount not exceeding $3,000 in any one year made by a life insurer under the maturity, death, or settlement agreement provisions in effect or elected by such minor under a life insurance policy or annuity contract, provided such policy, contract, or agreement shall provide for the payment or payments to such minor and if prior to such payment the insurer has not received written notice of the appointment of a duly qualified guardian of the property of the minor. No such minor shall be deemed competent to alienate the right to or to anticipate such payments. This section shall not be deemed to restrict the rights of minors set forth in 33-15-103.

(2) This section shall not be deemed to require any insurer to determine whether any other insurer may be effecting a similar payment to the same minor.

History: **En. Sec. 288, Ch. 286, L. 1959; R.C.M. 1947, 40-3731.**

Cross-References

Contractual capacity of minors, Title 41, ch. 1, part 3.

33-15-503. Forms for proof of loss to be furnished. An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance contract issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

History: **En. Sec. 289, Ch. 286, L. 1959; R.C.M. 1947, 40-3732.**

Cross-References

Multiple proofs required — unfair trade practice, 33-18-201.

33-15-504. Claims administration not waiver. Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of any provision of a policy or of any defense of the insurer thereunder:

(1) acknowledgment of the receipt of notice of loss or claim under the policy;

(2) furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted;

(3) investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

History: **En. Sec. 290, Ch. 286, L. 1959; R.C.M. 1947, 40-3733.**

33-15-505 through 33-15-510 reserved.

33-15-511. Exemption from execution of life insurance proceeds. (1) If a policy of insurance is effected by any person on the person's own life or on another life in favor of a person other than the applicant or, except in cases of transfer with intent to defraud creditors, if a policy of life insurance is assigned or in any way made payable to any person, the lawful beneficiary or assignee of the policy, other than the insured or the person effecting the insurance or executors or administrators of the insured or the person effecting the insurance, is entitled to its proceeds and avails against the creditors and representatives of the insured and of the person effecting the policy whether or not the right to change the beneficiary is reserved or permitted and whether or not the policy is made payable to the person whose life is insured if the beneficiary or assignee predecease that person. However, subject to the statute of limitations, the amount of any premiums for the insurance paid with intent to defraud creditors with interest on the premiums accrues to the creditor's benefit from the proceeds of the policy, but the insurer issuing the policy must be discharged of all liability by payment of its proceeds in accordance with its terms unless before the payment the insurer received written notice at its home office, by or in behalf of a creditor, of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specifications of the amount claimed.

(2) For the purposes of subsection (1), a policy must also be considered to be payable to a person other than the insured if and to the extent that a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by the clause.

History: En. Sec. 291, Ch. 286, L. 1959; R.C.M. 1947, 40-3734; amd. Sec. 1190, Ch. 56, L. 2009.

Cross-References

Exemptions from executions, Title 25, ch. 13, part 6.
Statutes of limitation, Title 27, ch. 2.

33-15-512. Exemption from execution of proceeds of group life — exception. (1) A policy of group life insurance or the proceeds of the policy payable to the individual insured or to the beneficiary under the policy may not be liable, either before or after payment, to be applied by any legal or equitable process to pay any debt or liability of the insured individual, of the individual's beneficiary, or of any other person having a right under the policy. The proceeds of the policy, when not made payable to a named beneficiary or to a third person pursuant to a facility-of-payment clause, may not constitute a part of the estate of the individual insured for the payment of the individual's debts.

(2) This section does not apply to group life insurance issued pursuant to Title 33, chapter 20, parts 10, 11, and 12, to a creditor covering the creditor's debtors to the extent that the proceeds are applied to payment of the obligation for the purpose of which the insurance was issued.

History: En. Sec. 292, Ch. 286, L. 1959; R.C.M. 1947, 40-3735; amd. Sec. 1191, Ch. 56, L. 2009.

Cross-References

Exemptions from executions, Title 25, ch. 13, part 6.
Bankruptcy proceedings — proceeds as exempt property, 31-2-106.

33-15-513. Exemption from execution of proceeds of disability insurance. The proceeds or other payments of all contracts of disability insurance and of provisions providing benefits on account of the insured's disability that are supplemental to life insurance or annuity contracts are exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for the insured's use.

History: En. Sec. 293, Ch. 286, L. 1959; R.C.M. 1947, 40-3736; amd. Sec. 1192, Ch. 56, L. 2009.

Cross-References

Exemptions from executions, Title 25, ch. 13, part 6.

33-15-514. Exemption from execution of proceeds of annuity contracts — assignability of rights. (1) The benefits, rights, privileges, and options that under any annuity contract are due or prospectively due the annuitant may not be subject to execution, the annuitant may not be compelled to exercise any rights, powers, or options, and creditors may not be allowed to interfere with or terminate the contract, except:

(a) as to amounts paid for or as premium on any annuity with intent to defraud creditors, with interest, and of which the creditor has given the insurer written notice at its home office prior to the making of the payments to the annuitant out of which the creditor seeks to recover.

The notice must specify the amount claimed or the facts that will enable the insurer to ascertain the amount and must set forth the facts that will enable the insurer to ascertain the annuity contract, the annuitant, and the payments sought to be avoided on the ground of fraud.

(b) the total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity contracts under which the person is an annuitant may not at any time exceed $250 a month for the length of time represented by the installments and the periodic payments in excess of $350 a month must be subject to garnishee execution;

(c) if the total benefits presently due and payable to any annuitant under all annuity contracts under which the person is an annuitant at any time exceed payment at the rate of $350 a month, then the court may order the annuitant to pay to a judgment creditor or apply on the judgment, in installments, the portion of the excess benefits that appear to the court to be just and proper, after due regard for the reasonable requirements of the judgment debtor and the debtor's family, if dependent upon the debtor, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(2) If the contract provides, the benefits, rights, privileges, or options accruing under the contract to a beneficiary or assignee may not be transferable or subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions contained in this section for the annuitant apply with respect to the beneficiary or assignee.

(3) An annuity contract within the meaning of this section is any obligation to pay certain sums at stated times during life or lives or for a specified term or terms, issued for a valuable consideration, regardless of whether or not the sums are payable to one or more persons, jointly or otherwise, but does not include payments under life insurance contracts at stated times during life or lives or for a specified term or terms.

History: En. Sec. 294, Ch. 286, L. 1959; R.C.M. 1947, 40-3737; amd. Sec. 1193, Ch. 56, L. 2009.

Cross-References

Exemptions from executions, Title 25, ch. 13, part 6.

Bankruptcy proceedings — proceeds as exempt property, 31-2-106.

Part 6
Electronic Delivery of Insurance Notices or Documents

33-15-601. Definitions. As used in this part, the following definitions apply:

(1) "Delivered by electronic means", "delivery by electronic means", or "electronic delivery" means:

(a) delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(b) (i) posting on an electronic network or site accessible by the internet through use of a mobile application, computer, mobile device, tablet, or any other electronic device; and

(ii) sending separate notice of the posting to the electronic mail address at which the party has consented to receive notice of the posting or using any other delivery method to which the party has consented.

(2) "Party" means a recipient of a notice or document required as part of an insurance transaction and includes an applicant, insured, policyholder, certificate holder, or annuity contract holder.

History: En. Sec. 1, Ch. 369, L. 2015.

33-15-602. Electronic delivery permitted. (1) Subject to the requirements of Title 30, chapter 18, 33-19-202(7)(c), and this part, a notice to a party or any other document that is required in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means.

(2) Electronic delivery of a notice or document as provided in this part is equivalent to any delivery method otherwise required by law, including delivery by first-class mail, first-class mail postage prepaid, certified mail, or certificate of mailing.

(3) A requirement in law that a notice or document provided to a party expressly requires verification or acknowledgment of receipt of the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(4) If an insurer has reason to believe that a party is not receiving notices or documents that the insurer attempts to deliver by electronic means, including if the insurer attempts

delivery by electronic means and receives a notice that the delivery by electronic means has failed, the insurer shall deliver the notices or documents by first-class mail or by any other delivery method required for the notices or documents.

(5) An insurer may not impose on a party a fee or charge because the party:

(a) refuses to consent to delivery of a notice or a document by electronic means; or

(b) withdraws consent to delivery of a notice or a document by electronic means.

History: En. Sec. 2, Ch. 369, L. 2015.

33-15-603. Conditions for electronic delivery. (1) An insurer may use electronic delivery of a notice or a document to a party under this part if the insurer meets the requirements of subsection (2) and the party:

(a) has affirmatively consented to the electronic delivery method and has not withdrawn the consent;

(b) is provided, before or at the time of giving consent, with a clear and conspicuous statement informing the party of:

(i) the right of the party at any time to have the notice or the document provided or made available in paper form or by another nonelectronic form;

(ii) the right of the party at any time to withdraw consent to have a notice or document delivered by electronic means and any conditions or consequences imposed if consent is withdrawn;

(iii) the specific notice or document or categories of notices or documents that may be delivered by electronic means during the course of the relationship between the insurer and the party;

(iv) the means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means; and

(v) the procedures for a party to follow to update information needed to contact the party electronically and to withdraw consent to have a notice or a document delivered by electronic means; and

(c) is provided, before or at the time of giving consent, with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means. The party shall provide electronic consent to the hardware and software requirements or confirm consent electronically in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means.

(2) After the party consents as provided in subsection (1), if a change occurs in hardware or software needed to access or retain a notice or document delivered by electronic means that creates a material risk that the party will not be able to access or retain a notice or document to which the consent applies, the insurer shall provide the party with a statement that:

(a) provides information regarding the revised hardware or software requirements for access to and retention of a notice or document delivered by electronic means; and

(b) recognizes the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed under subsection (1)(b)(ii).

(3) Consent to delivery by electronic means remains in effect following a policy modification or renewal if the original consent makes clear that consent continues after a policy modification or renewal.

History: En. Sec. 3, Ch. 369, L. 2015.

33-15-604. Withdrawal of consent to electronic delivery. (1) Withdrawal of consent to electronic delivery does not affect the legal effectiveness, validity, or enforceability of a notice or a document that is delivered by electronic means to a party before the withdrawal of consent is effective.

(2) (a) Except as provided in subsection (2)(b), withdrawal of consent by a party becomes effective 15 days after the insurer receives notice of the withdrawal pursuant to the insurer's noticed procedures.

(b) Except as provided in 33-15-603(2) or if a party updates contact information pursuant to the insurer's noticed procedures, a withdrawal becomes effective immediately upon the insurer learning that the electronic delivery method currently used is no longer an effective delivery mechanism with respect to the party.

(3) Failure by an insurer to comply with 33-15-603(2) may be treated, at the election of the party, as a withdrawal of consent, but the party shall communicate the withdrawal pursuant to the insurer's noticed procedures.

History: **En. Sec. 4, Ch. 369, L. 2015.**

33-15-605. Protection of information. An insurer delivering a notice or a document by electronic means shall take appropriate and necessary measures reasonably calculated to ensure that the system for furnishing the notices or documents:

(1) results in actual receipt of transmitted information; and

(2) protects the confidentiality of personal information as defined in 33-19-104.

History: **En. Sec. 5, Ch. 369, L. 2015.**

33-15-606. Validity of electronic delivery. The legal effectiveness, validity, or enforceability of a contract or policy of insurance executed by a party may not be denied solely because the contract or policy was delivered by electronic means if the insurer has obtained the electronic consent of the party as required in 33-15-603.

History: **En. Sec. 6, Ch. 369, L. 2015.**

33-15-607 through 33-15-609 reserved.

33-15-610. Application to other laws. The provisions of this part do not affect requirements related to content or timing of a notice or document required by laws affecting insurance policies, notices, or documents.

History: **En. Sec. 7, Ch. 369, L. 2015.**

33-15-611. Rulemaking. The commissioner may adopt rules necessary to implement the provisions of this part.

History: **En. Sec. 8, Ch. 369, L. 2015.**

Parts 7 through 10 reserved

Part 11

Property or Casualty Insurance — Premium Changes, Cancellation, and Claim Information

Part Cross-References

Casualty insurance, Title 33, ch. 23.

Property insurance, Title 33, ch. 24.

33-15-1101. Purpose — applicability. (1) The purpose of this part is to protect the public with regard to insurance transactions that involve cancellation, renewal, nonrenewal, or premium increases on contracts of property or casualty insurance by:

(a) regulating the grounds for midterm cancellation of an insurance policy;

(b) except as provided in 33-15-1108, prohibiting midterm increases in premiums;

(c) increasing the opportunity for insureds to shop for replacement or substitute insurance;

(d) reducing the opportunity for breach of contract, misrepresentation by omission or untimely disclosure, and unfair discrimination among insureds; and

(e) increasing the opportunity for insurance producers to compete freely.

(2) This part applies to those forms of insurance defined in 33-1-206 and 33-1-210, except to the extent they conflict with chapter 23 of this title.

(3) This part does not limit the activities that may constitute undefined unfair trade practices prohibited by 33-18-1003. The commissioner may apply other provisions of this code to insurance transactions involving cancellation, renewal, nonrenewal, or premium increases on contracts of property or casualty insurance. Policies may provide terms more favorable to insureds than are required by this part. The rights provided by this part are in addition to and do not prejudice any other rights that the insured may have under common law, statutes, or rules.

History: **En. Sec. 1, Ch. 120, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1, Ch. 501, L. 2003.**

33-15-1102. Definitions. As used in this part, the following definitions apply unless the context requires otherwise:

(1) "Anniversary date" means the month and day that rates, rating plans, and rating systems are initially applied to a policy in effect. The term includes each annual anniversary thereafter unless the insurer establishes a different date by a filing with the commissioner.

(2) "Cancellation" means the decision by the insurer to terminate an insurance policy prior to the expiration of its term.

(3) "Classification" means an arrangement of insurance risks into an underwriting or rating group according to a classification system used by an insurer as a basis for tabulating statistical experience and determining premium rates.

(4) "Classification system" means a schedule of classifications and a rule used by an insurer for determining the classifications applicable to an insured.

(5) "Insurer" means an insurer authorized to transact property or casualty insurance in this state or an unauthorized insurer transacting surplus lines insurance in this state.

(6) "Premium" means the contractual consideration charged to an insured for insurance for a specified period of time, regardless of the timing of actual charges.

(7) "Rate" means a monetary amount applied to the units of exposure assigned to a classification and used by an insurer to determine the premium for an insured.

(8) "Rating plan" means a rule used by an insurer to calculate:

(a) the premium for an insured; and

(b) the parameter values used in such calculation after application of classification premium rates to units of exposure.

(9) "Renewal" means an agreement between an insurer and an insured to extend or continue an existing insurance policy for 90 days or more.

History: En. Sec. 2, Ch. 120, L. 1987; amd. Sec. 4, Ch. 180, L. 1991.

33-15-1103. Midterm cancellation. (1) An insurer may not cancel an insurance policy before either the expiration of the agreed term or 1 year from the effective date of the policy or renewal date, whichever is less, except:

(a) for reasons specifically allowed by statute;

(b) for failure to pay a premium when due; or

(c) on grounds stated in the policy which pertain to the following:

(i) material misrepresentation;

(ii) substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk when the contract was written;

(iii) substantial breaches of contractual duties, conditions, or warranties;

(iv) determination by the commissioner that continuation of the policy would place the insurer in violation of this code;

(v) financial impairment of the insurer; or

(vi) any other reason approved by the commissioner.

(2) Except as provided in 33-23-401, cancellation under subsection (1) is not effective until 10 days after a notice of cancellation is either delivered or mailed to the insured.

(3) Subsections (1) and (2) do not apply to a newly issued insurance policy if the policy has been in effect less than 60 days at the time the notice of cancellation is mailed or delivered. A cancellation under this subsection is not effective until 10 days after the notice is delivered or mailed to the insured.

(4) If a policy has been issued for a term longer than 1 year and if either the premium is prepaid or an agreed term is guaranteed for additional premium consideration, the insurer may not cancel the policy except:

(a) for reasons specifically allowed by statute;

(b) for failure to pay a premium when due; or

(c) on grounds stated in the policy which pertain to those grounds listed in subsection (1)(c).

History: En. Sec. 3, Ch. 120, L. 1987; amd. Sec. 1, Ch. 263, L. 2005.

33-15-1104. Anniversary cancellation — anniversary rate increases. (1) An insurer may issue a policy for a term longer than 1 year or for an indefinite term if the policy contains a clause that allows cancellation by the insurer if the insurer gives notice 45 days prior to an anniversary date.

(2) If a policy has been issued for a term longer than 1 year and for additional premium consideration an annual premium has been guaranteed, the insurer may not increase the annual premium for the term of that policy.

History: En. Sec. 4, Ch. 120, L. 1987; amd. Sec. 1, Ch. 339, L. 2003.

33-15-1105. Nonrenewal — renewal premium. (1) (a) An insured has a right to reasonable notice of nonrenewal. Unless otherwise provided by statute or unless a longer term is provided in the policy, at least 45 days prior to the expiration date provided in the policy, an insurer who does not intend to renew a policy beyond the agreed expiration date shall mail or deliver to the insured a notice of the intention not to renew. The insurer shall also mail or deliver a copy to the insured's insurance producer.

(b) Notification of nonrenewal to the insured's insurance producer via electronic transfer of data or by an electronic data retrieval device meets the requirement of a mailed or delivered copy.

(2) An insurer shall give notice of premium due not more than 60 days or less than 30 days before the due date of a renewal premium. The notice must clearly state the effect of nonpayment of the premium on or before the due date.

(3) Subsections (1) and (2) do not apply if:

(a) the insured has obtained insurance elsewhere, has accepted replacement coverage, or has requested or agreed to nonrenewal; or

(b) the policy is expressly designated as nonrenewable.

(4) An insurer may not refuse to renew a property and casualty insurance policy on the basis of a single loss occurring during the policy period unless the insurer has previously disclosed in writing to the insured, at the time that the insured applied for the insurance or prior to the insured's renewal, that a single loss is among the insurer's criteria for nonrenewal.

(5) (a) For the purposes of this subsection (5), the following definitions apply:

(i) "Claim" means a contact with an insurer by an insured or third party for the purpose of seeking payment. An inquiry into coverage on a property and casualty insurance policy is not claim activity unless:

(A) a payment is made;

(B) a reserve is established or loss adjustment expenses are incurred; or

(C) a written, formal denial of the claim is issued to the insured or claimant.

(ii) "Inquiry" means a request for information regarding the terms, conditions, or coverages offered under a property and casualty insurance policy that does not result in a claim.

(b) An insurer may not use a direct or indirect inquiry as the basis for declining or not renewing insurance coverage or a binder of insurance coverage or for increasing the insurance premium.

(c) An inquiry may not be considered a claim under 33-18-201.

(d) An insurer may not submit to any insurance-support organization or consumer reporting agency an insured's name if the insured made an inquiry about terms or coverage of an insurance policy.

History: En. Sec. 5, Ch. 120, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 21, Ch. 531, L. 1997; amd. Sec. 1, Ch. 364, L. 1999; amd. Sec. 2, Ch. 339, L. 2003; amd. Sec. 2, Ch. 263, L. 2005; amd. Sec. 1, Ch. 498, L. 2005.

33-15-1106. Renewal with altered terms. (1) If an insurer offers or purports to renew a policy but on less favorable terms, at a higher rate, or at a higher rating plan, the new terms, rate, or rating plan take effect on the policy renewal date only if the insurer has mailed or delivered notice of the new terms, rate, or rating plan to the insured at least 45 days before the expiration date.

(2) This section does not apply if the increase in the rate or the rating plan, or both, results from a classification change based on the altered nature or extent of the risk insured against.

History: En. Sec. 6, Ch. 120, L. 1987; amd. Sec. 4, Ch. 699, L. 1991; amd. Sec. 22, Ch. 531, L. 1997; amd. Sec. 3, Ch. 339, L. 2003.

33-15-1107. Information about grounds for nonrenewal. (1) If the insurer or insurance producer receives a written request from an insured within 60 business days from the date on which the insurer mailed a notice of cancellation or nonrenewal to the insured, the insurer or insurance producer shall, within 21 days of receiving the insured's written request, furnish the insured the information that the insurer or insurance producer used to make its decision. A notice is not effective unless it contains adequate information about the insured's right to make the request.

(2) This section does not apply if the ground for cancellation or nonrenewal is nonpayment of the premium and the reason is stated in the notice.

History: **En. Sec. 7, Ch. 120, L. 1987; amd. Sec. 26, Ch. 472, L. 1999.**

33-15-1108. Limitation on midterm premium increases. (1) In any case involving property or casualty insurance that is subject to this part, the insurer may not unilaterally increase the rate charged or decrease the coverage provided for the contract period unless:

(a) there is a change in risk during that period because of the addition or removal of persons or property that was included in the rate at last renewal;

(b) the risk was misrepresented by the insured; or

(c) the insured requests a policy change that increases the rate because of that specific request.

(2) This section does not prohibit the cancellation of a policy for any other reason permitted by the policy or by law during an initial policy period not to exceed 60 days.

(3) This section does not prohibit an insurer from providing a benefit or premium reduction relating to preventative measures taken by a policyholder under 33-24-110.

History: **En. Sec. 2, Ch. 501, L. 2003; amd. Sec. 10, Ch. 62, L. 2019; amd. Sec. 2, Ch. 105, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 2, Ch. 105, L. 2025. Amendment effective October 1, 2025.

33-15-1109 and 33-15-1110 reserved.

33-15-1111. Home owner insurance not affected by day-care operations. (1) No insurer writing home owner insurance in this state may deny an applicant home owner insurance or cancel or refuse to renew a home owner insurance policy covering a dwelling located in this state for the principal reason that an insured under the policy operates at the insured location a day-care facility, as defined in 52-2-703, that satisfies the requirements of 52-2-723 or 52-2-724.

(2) This section does not prevent an insurer from excluding or limiting coverage with respect to liability or property losses arising out of an insured's business pursuits, including those related to the operation of a day-care facility.

History: **En. Sec. 8, Ch. 120, L. 1987.**

Cross-References

Written notice required for cancellation or nonrenewal of insurance policies on homes — penalty, 33-23-401.

33-15-1112 through 33-15-1120 reserved.

33-15-1121. Unfair trade practices. (1) The failure of an insurer to comply with this part constitutes an unfair trade practice under 33-18-1003.

(2) Midterm premium increases and policy coverage reductions not in compliance with this part that are attempted or executed constitute unfair trade practices under 33-18-1003.

History: **En. Sec. 9, Ch. 120, L. 1987.**

33-15-1122 through 33-15-1125 reserved.

33-15-1126. Disclosure of certain claim information on insurance policies. (1) On request of a policyholder, an insurer shall provide to the policyholder, or to an insurance producer designated by the policyholder, a list of claims charged against the policy.

(2) The information must include:

(a) the date and description of the claim;

(b) details relating to the cause and disposition of the claim; and

(c) a list of the claims charged against the policy, including payments made on each claim.

(3) The information must be provided within 10 days of the policyholder's request.

(4) The information provided under this section is confidential insurance information. The information may be used by the policyholder for internal management purposes or for procuring insurance products but may not be disclosed for any other purpose without the express written consent of the insurer.

(5) This section does not apply to workers' compensation insurance.

History: En. Sec. 1, Ch. 267, L. 2015.

CHAPTER 16
RATES — RATING AND ADVISORY ORGANIZATIONS

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Part 1
General Provisions

33-16-101. Purpose and intent. (1) The purpose of this chapter is to promote the public welfare by regulating insurance rates as herein provided to the end that they shall not be excessive, inadequate, or unfairly discriminatory, to authorize the existence and operation of qualified rating organizations and advisory organizations and require that specified rating services of such rating organizations be generally available to all admitted insurers, and to authorize cooperation between insurers in ratemaking and other related matters.

(2) It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis, and nothing in this chapter is intended to give the commissioner power to fix and determine a rate level by classification or otherwise.

History: En. Sec. 1, Ch. 362, L. 1969; R.C.M. 1947, 40-3634.

33-16-102. Definitions. In this chapter, the following definitions apply:

(1) "Advisory organization" means each person, other than an admitted insurer, whether located within or outside this state, who prepares policy forms or makes underwriting rules incident to but not including the making of rates, rating plans, or rating systems or who collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other

statistical information and data and acts in an advisory, as distinguished from a ratemaking, capacity. A licensed attorney, acting in the usual course of the profession, may not be considered an advisory organization.

(2) "Dividend" means:

(a) a noncontractual and nonrecoverable payment or credit declared by an insurer's board of directors and paid out or credited out of earned surplus to policyholders, members, or subscribers; or

(b) in the absence of earned surplus, a noncontractual and nonrecoverable payment or credit declared by an insurer's board of directors and paid to policyholders, members, or subscribers with the written permission of the commissioner. The commissioner may grant permission only if the payment of the dividend or credit will not reduce the insurer's capital and surplus below an amount three times the minimum capital required under 33-2-109.

(3) "Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory, or other organization.

(4) "Rating organization" means each person, other than an admitted insurer, whether located within or outside this state, with the object or purpose of making rates, rating plans, or rating systems. Two or more admitted insurers who act in concert for the purpose of making rates, rating plans, or rating systems and who do not operate within the specific authorizations contained in 33-16-105, 33-16-302, 33-16-304, 33-16-305, and 33-16-307 must be considered a rating organization. A single insurer may not be considered a rating organization.

(5) "Subscriber" means an insurer who is furnished at its request with rates and rating manuals by a rating organization of which the insurer is not a member or with advisory services by an advisory organization of which it is not a member.

(6) "Willful" or "willfully", in relation to an act or omission that constitutes a violation of this chapter, means with actual knowledge or belief that the act or omission constitutes a violation and with specific intent to commit the violation.

History: En. Secs. 2, 3, 4, 5, Ch. 362, L. 1969; R.C.M. 1947, 40-3635, 40-3636, 40-3637, 40-3638; amd. Sec. 27, Ch. 472, L. 1999; amd. Sec. 42, Ch. 227, L. 2001.

33-16-103. Application. This chapter applies to all insurers and all kinds of insurance, except that nothing contained in this chapter applies to:

(1) life insurance;

(2) disability insurance, except medicare supplement insurance subject to the provisions of chapter 22, part 9;

(3) reinsurance, except joint reinsurance as provided in 33-16-307;

(4) insurance against loss of or damage to aircraft, their hulls, accessories, and equipment, or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of aircraft;

(5) insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies; or

(6) surplus lines insurance as defined in 33-2-301.

History: En. Sec. 6, Ch. 362, L. 1969; amd. Sec. 1, Ch. 558, L. 1977; R.C.M. 1947, 40-3639; amd. Sec. 1, Ch. 126, L. 1981; amd. Sec. 1, Ch. 400, L. 1989; amd. Sec. 1, Ch. 682, L. 1989.

33-16-104. Payment of dividends, savings, or unabsorbed premium deposits not prohibited or regulated — plan for payment not rating system. Nothing in this chapter may be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers may not be considered a rating plan or system. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers does not relieve the insurer from complying with any requirements of this chapter regarding rating plans or systems.

History: En. Sec. 33, Ch. 362, L. 1969; R.C.M. 1947, 40-3666; amd. Sec. 28, Ch. 472, L. 1999.

33-16-105. Maintenance of records. Every insurer, rating organization, or advisory organization and every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance shall maintain reasonable records, of the type and kind reasonably adapted to its method of operation, of its experience or the experience of its members and of the data, statistics, or information collected or used by it in connection with the rates, rating plans, rating systems, underwriting rules, policy or bond forms, surveys or inspections made or used by it so that such records will be available at all reasonable times to enable the commissioner to determine whether such organization, insurer, group, or association and, in the case of an insurer or rating organization, every rate, rating plan, and rating system made or used by it complies with the provisions of this chapter applicable to it. The maintenance of such records in the office of a licensed rating organization of which an insurer is a member or subscriber will be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the rates, rating plans, rating systems, or underwriting rules of such organization. Such records shall be maintained in an office within this state or shall be made available for examination or inspection within this state by the commissioner at any time upon reasonable notice.

History: **En. Sec. 21, Ch. 362, L. 1969; amd. Sec. 1, Ch. 469, L. 1977; R.C.M. 1947, 40-3654(1).**

33-16-106. Examination by commissioner of rating organizations, admitted insurers, officers, managers, insurance producers, and employees — expense. (1) (a) The commissioner may, as often as may be reasonable and necessary, make or cause to be made an examination of each licensed rating organization. The commissioner may, as often as may be reasonable and necessary, make or cause to be made an examination of any advisory organization or group, association, or other organization of insurers that engages in joint underwriting or joint reinsurance.

(b) In lieu of an examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state or by the national association of insurance commissioners.

(c) In examining any organization, group, or association pursuant to this section, the commissioner shall ascertain whether an organization, group, or association and, in the case of a rating organization, any rate or rating system made or used by it, complies with the requirements and standards of this chapter applicable to it.

(2) The commissioner may, at any reasonable time, make or cause to be made an examination of every admitted insurer transacting any class of insurance to which the provisions of this chapter are applicable to ascertain whether the insurer and every rate and rating system used by it for every class of insurance complies with the requirements and standards of this chapter applicable to it. The examination may not be a part of a periodic general examination participated in by representatives of more than one state.

(3) The officers, managers, insurance producers, and employees of any organization, group, association, or insurer may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation, together with all data, statistics, and information of every kind and character collected or considered by an organization, group, association, or insurer in the conduct of the operations to which the examination relates.

(4) The reasonable cost of any examination authorized by this article must be paid by the organization, group, association, or insurer to be examined.

History: **En. Secs. 22, 23, 24, 25, Ch. 362, L. 1969; R.C.M. 1947, 40-3655, 40-3656, 40-3657, 40-3658; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 19, Ch. 451, L. 1993.**

33-16-107. Information not to be willfully withheld. No person, insurer, or organization shall willfully withhold information from or knowingly give false or misleading information to the commissioner or to any rating organization, advisory organization, insurer, or group, association, or other organization of insurers which will affect the rates, rating systems, or premiums for the classes of insurance to which the provisions of this chapter are applicable.

History: **En. Sec. 32, Ch. 362, L. 1969; R.C.M. 1947, 40-3665(a).**

Cross-References

Penalty for violation of chapter, 33-16-114.

33-16-108 through 33-16-110 reserved.

33-16-111. Issuance of order — suspension or revocation of certificate of authority or license. If, after a hearing pursuant to 33-16-206, the commissioner finds:

(1) that an insurer, a rating organization, an advisory organization, or a group, association, or other organization of insurers that engages in joint underwriting or joint reinsurance is in violation of the provisions of this chapter applicable to it, other than the provisions dealing with rates, rating plans, or rating systems, the commissioner may issue an order to the insurer, organization, group, or association that has been the subject of the hearing, specifying in what respects the violation exists and requiring compliance within a reasonable time;

(2) that the violation of any of the provisions of this chapter applicable to it by any insurer or rating organization that has been the subject of hearing was willful, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of the insurer or the license of the rating organization with respect to the class of insurance that has been the subject matter of the hearing;

(3) that any rating organization has willfully engaged in any fraudulent or dishonest act or practices, the commissioner may suspend or revoke, in whole or in part, the license of the organization, in addition to any other penalty provided in this chapter.

History: **En. Sec. 29, Ch. 362, L. 1969; R.C.M. 1947, 40-3662(part); amd. Sec. 1194, Ch. 56, L. 2009.**

Cross-References

Hearings by Commissioner, 33-1-701.

Revocation or suspension of certificate of authority, 33-2-118, 33-2-119.

Unfair trade practices, Title 33, ch. 18.

33-16-112. Failure to comply with order — suspension or revocation of license or certificate. In addition to other penalties provided in this code, the commissioner may suspend or revoke, in whole or in part, the license of any rating organization or the certificate of authority of any insurer with respect to the class or classes of insurance specified in the order that fails to comply within the time limited by the order or any extension of the order that the commissioner may grant, with an order of the commissioner lawfully made pursuant to 33-16-111 and 33-16-211 and effective pursuant to 33-16-113.

History: **En. Sec. 30, Ch. 362, L. 1969; R.C.M. 1947, 40-3663; amd. Sec. 1195, Ch. 56, L. 2009.**

Cross-References

Revocation or suspension of certificate of authority, 33-2-118, 33-2-119.

33-16-113. Appeal from order or decision of commissioner. Any person, insurer, or rating organization aggrieved by any order or decision made by the commissioner under this chapter may appeal to the district court of the county where the aggrieved party may reside or has a principal place of business in this state or to the district court of Lewis and Clark County, Montana. The appeal must be taken within 30 days from the making and filing of the order or decision by filing in the office of the commissioner a notice of the appeal in writing. The commissioner shall, within 20 days after filing of the notice, make and return to the district court a full and complete certified transcript of the finding and order appealed from and of all parts relative to the finding and order on file in the commissioner's office, including the notice of appeal. Upon filing of the certified transcript, all matters involved in the appeal must be brought on for trial upon the merits at the next term of the court after the filing of the transcript unless otherwise ordered by the court. Upon the trial, the findings of fact on which the order is based must be prima facie evidence of the matters stated. During the pendency of the proceedings upon review, the order of the commissioner is suspended, but in the event of a final determination against any insurer, any overcharge by the insurer during review must be refunded to the persons entitled to the refund.

History: **En. Sec. 31, Ch. 362, L. 1969; R.C.M. 1947, 40-3664; amd. Sec. 1196, Ch. 56, L. 2009.**

Cross-References

Judicial appeals of contested administrative proceedings, 2-4-702.

Appeals from Commissioner's decision, 33-1-711.

33-16-114. Penalty. (1) A person, insurer, organization, group, or association that fails to comply with a final order of the commissioner under this chapter is liable to the state in an amount not exceeding $50. If the failure is willful, the person or entity is liable to the state in an amount not exceeding $5,000 for the failure. The commissioner shall collect the amount payable and may bring an action in the name of the people of the state of Montana to enforce collection. The penalties may be in addition to any other penalties provided by law.

(2) A willful violation of the provisions of this chapter by any person is a misdemeanor.

History: **En. Sec. 32, Ch. 362, L. 1969; R.C.M. 1947, 40-3665(b), (c); amd. Sec. 1197, Ch. 56, L. 2009.**

Cross-References

Legal actions by state agencies — Attorney General to be notified, 25-1-501.

33-16-115. Acts done by authority of chapter not violation of other laws. No act done, action taken, or agreement made pursuant to the authority conferred by this chapter shall constitute a violation of or grounds for prosecution or civil proceedings under any other law of this state heretofore or hereafter enacted which does not specifically refer to insurance.

History: **En. Sec. 34, Ch. 362, L. 1969; R.C.M. 1947, 40-3667.**

Cross-References

Unlawful price fixing, 30-14-205.

33-16-116. Administration or enforcement — supplementation or modification. The administration and enforcement of this chapter shall be governed solely by the provisions of this chapter. Except as provided in this chapter, no other law relating to insurance and no other provisions in this code heretofore or hereafter enacted shall apply to or be construed as supplementing or modifying the provisions of this chapter unless such other law or other provision expressly so provides and specifically refers to the sections of this chapter which it intends to supplement or modify.

History: **En. Sec. 35, Ch. 362, L. 1969; R.C.M. 1947, 40-3668.**

33-16-117. Wildfire risk score in residential property evaluation in rating. (1) An insurer that uses a wildfire risk score in connection with property evaluation in rating of residential real property shall, on the request of an insured, the insured's insurance producer, or an applicant for residential property insurance coverage for the wildfire risk score, provide the following information to the insured or the applicant to enhance transparency:

(a) the current wildfire risk score of the residential property;

(b) the range of possible wildfire risk scores under the model used;

(c) the name of the person or entity that created the wildfire risk score;

(d) the date on which the wildfire risk score was created; and

(e) the key factors that adversely affected the wildfire risk score of the residential property.

(2) An insurer shall provide to a property owner the information referred to in subsection (1) by no later than 30 days after receiving a request for the information.

(3) For the purposes of this section, the following definitions apply:

(a) (i) "Insurer" means admitted insurers in this state.

(ii) The term does not apply to nonadmitted insurers.

(b) "Wildfire risk score" means a numerical value, rating, or categorization derived from a statistical tool, modeling system, algorithm, or other process that is used to measure or assess wildfire risk for a residential property for the purposes of property evaluation in rating.

History: **En. Sec. 1, Ch. 485, L. 2025.**

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

Part 2
Rates and Rating Plans

33-16-201. Standards applicable to rates. The following standards apply to the making and use of rates pertaining to all classes of insurance to which the provisions of this chapter are applicable:

(1) (a) Rates may not be excessive or inadequate, and they may not be unfairly discriminatory.

(b) A rate may not be held to be excessive unless the rate is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which the rate is applicable.

(c) A rate may not be held to be inadequate unless the rate is unreasonably low for the insurance provided and the continued use of the rate endangers the solvency of the insurer using the rate or unless the rate is unreasonably low for the insurance provided and the use of the rate by the insurer has, or if continued will have, the effect of destroying competition or creating a monopoly.

(2) (a) Consideration must be given, when applicable, to past and prospective loss experience within and outside this state, to revenue and profits from reserves, to conflagration and catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses, both countrywide and those specially applicable to this state, and to all other factors, including judgment factors, considered relevant within and outside this state. In the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent 5-year period for which experience is available.

(b) Consideration may also be given in the making and use of rates to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

(3) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of the insurer or group with respect to any kind of insurance or with respect to any subdivision or combination of insurance.

(4) (a) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for separate risks in accordance with rating plans that establish standards for measuring variations in hazards or expense provisions, or both. The standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established, based on size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations.

(b) Special risk classifications may be established for private passenger automobile policies. Special risk classifications may be based on favorable aspects of an insured individual's claims history. Special risk classifications may not be established based on adverse information contained in an insured individual's driving record that is 3 years old or older.

(c) Special risk classifications may be established for commercial automobile policies. Special risk classifications for commercial automobile policies may be based on favorable aspects of an insured's claims history. Special risk classifications for commercial automobile policies may not be established based on adverse information contained in an insured's claims history or driving records that is 5 years old or older.

(d) Special risk classifications may be established for personal homeowner policies. Special risk classifications may be based on favorable aspects of an insured individual's claims history. Special risk classifications may not be established based on adverse information contained in an insured individual's claims history that is 7 years old or older.

(e) Classifications and modifications apply to all risks under the same or substantially the same circumstances or conditions.

(f) As used in subsection (4)(b), "private passenger automobile policy" means an automobile insurance policy issued to individuals or families but does not include policies known as commercial automobile policies.

(g) As used in subsection (4)(d), "personal homeowner policies" means property insurance under 33-1-210 that is sold by an insurer for personal, family, or household purposes.

History: En. Sec. 7, Ch. 362, L. 1969; amd. Sec. 1, Ch. 54, L. 1973; amd. Sec. 1, Ch. 104, L. 1973; R.C.M. 1947, 40-3640; amd. Sec. 1, Ch. 320, L. 1995; amd. Sec. 1, Ch. 239, L. 2011; amd. Sec. 1, Ch. 129, L. 2021; amd. Sec. 1, Ch. 174, L. 2021.

33-16-202. Recording and reporting of loss and expense experience. (1) The commissioner may promulgate and may modify reasonable rules and statistical plans, reasonably adapted to each of the rating systems used, which must be used by each insurer in the recording and reporting of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in form and detail as necessary to aid the commissioner in determining whether rates comply with the applicable standards of this chapter. The rules and plans may also provide for the recording and reporting of expense experience items that are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience.

(2) In promulgating rules and plans, the commissioner shall give consideration to the rating systems in use in this state and, in order that the rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for rating systems in other states. An insurer may not be required to record or report its loss experience on a classification basis that is inconsistent with the rating system used by it.

(3) The commissioner may designate one or more rating organizations or other agencies to assist in gathering and making compilations of loss and expense experience, and the compilations must be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

History: **En. Sec. 36, Ch. 362, L. 1969; R.C.M. 1947, 40-3669; amd. Sec. 47, Ch. 379, L. 1995.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

Promulgation of rules by Commissioner, 33-1-313.

33-16-203. Rates filed. (1) Every insurer, rating organization, or advisory organization shall file with the commissioner all rates intended for use within this state, together with supporting data sufficient to substantiate the filing. The filing required by this subsection may be made by rating organizations on behalf of their members and subscribers. However, this provision does not prohibit a member or subscriber from filing rates on its own behalf. Any deviations from a rating organization's rates by a member or subscriber must be filed with the commissioner and must be accompanied by supporting data.

(2) Rates filed must provide for a premium reduction to:

(a) qualified insured operators who are 55 years of age or older in accordance with 33-16-222; or

(b) qualified members of the Montana national guard in accordance with 33-16-230.

(3) Rates filed may provide a benefit or premium reduction for preventative measures taken by the insured for homeowner's insurance under 33-24-110.

History: **En. Sec. 21, Ch. 362, L. 1969; amd. Sec. 1, Ch. 469, L. 1977; R.C.M. 1947, 40-3654(2); amd. Sec. 1, Ch. 241, L. 1979; amd. Sec. 7, Ch. 49, L. 1987; amd. Sec. 2, Ch. 576, L. 2005; amd. Sec. 3, Ch. 105, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 3, Ch. 105, L. 2025. Amendment effective October 1, 2025.

33-16-204. Review of rates on request by aggrieved person. (1) A person aggrieved by any rate charged, rating plan, rating system, or underwriting rule followed or adopted by an insurer or rating organization may request the insurer or rating organization to review the manner in which the rate, plan, system, or rule has been applied with respect to insurance afforded the person. The request may be made by the person's authorized representative and must be written.

(2) If the request is not granted within 30 days after it is made, the requester may treat it as rejected.

(3) Any person aggrieved by the action of an insurer or rating organization in refusing the review requested or in failing or refusing to grant all or part of the relief requested may file a written complaint and request for hearing with the commissioner, specifying the grounds relied upon. If the commissioner has information concerning a similar complaint, the commissioner may deny the hearing. If the commissioner believes that probable cause for the complaint does not exist or that the complaint is not made in good faith, the commissioner shall deny the hearing. Otherwise, and if the commissioner finds that the complaint charges a violation of this chapter and that the complainant would be aggrieved if the violation is proven, the commissioner shall proceed as provided in 33-16-205.

History: **En. Sec. 26, Ch. 362, L. 1969; R.C.M. 1947, 40-3659; amd. Sec. 1198, Ch. 56, L. 2009.**

Cross-References

Public documents open to public examination, Art. II, sec. 9, Mont. Const.; 2-6-1003.

33-16-205. Noncompliance of rates — notice. If, after examination of an insurer, rating organization, advisory organization, or group, association, or other organization of insurers that engages in joint underwriting or joint reinsurance or upon the basis of other information or upon sufficient complaint as provided in 33-16-204, the commissioner has good cause to believe that the insurer, organization, group, or association or any rate, rating plan, or rating system made or used by the insurer or rating organization does not comply with the requirements and standards of this chapter applicable to it, the commissioner shall, unless the commissioner has good cause to believe that the noncompliance is willful, give notice, in writing, to the insurer, organization, group, or association stating in what manner and to what extent the noncompliance is alleged to exist and specifying a reasonable time, not less than 10 days after receipt, in which the noncompliance may be corrected.

History: En. Sec. 27, Ch. 362, L. 1969; R.C.M. 1947, 40-3660; amd. Sec. 9, Ch. 416, L. 1999.

33-16-206. Hearings — notice — subject of hearing. (1) If the commissioner has good cause to believe the noncompliance to be willful or if within the period prescribed by the commissioner in the notice required by 33-16-205 the insurer, organization, group, or association does not make changes that may be necessary to correct the noncompliance specified by the commissioner or establish to the satisfaction of the commissioner that the specified noncompliance does not exist, then the commissioner may hold a public hearing in connection with the noncompliance, provided that within a reasonable period of time, which may not be less than 10 days before the date of hearing, the commissioner mails written notice specifying the matters to be considered at the hearing to the insurer, organization, group, or association. If notice has not been given as provided in 33-16-205, the notice must state in what manner and to what extent noncompliance is alleged to exist.

(2) The hearing may not include any additional subjects not specified in the notices required by 33-16-205 or this section.

History: En. Sec. 28, Ch. 362, L. 1969; R.C.M. 1947, 40-3661; amd. Sec. 1199, Ch. 56, L. 2009.

Cross-References

Hearings by Commissioner, 33-1-701.

33-16-207 through 33-16-210 reserved.

33-16-211. Order prohibiting use of rate or rating system. If, after a hearing pursuant to 33-16-206, the commissioner finds that any rate, rating plan, or rating system violates the provisions of this chapter applicable to it, the commissioner may issue an order to the insurer or rating organization that has been the subject of the hearing, specifying in what respects the violation exists and stating when, within a reasonable period of time, the further use of the rate or rating system by the insurer or rating organization in contracts of insurance made after that time is prohibited.

History: En. Sec. 29, Ch. 362, L. 1969; R.C.M. 1947, 40-3662(part); amd. Sec. 1200, Ch. 56, L. 2009.

33-16-212 through 33-16-220 reserved.

33-16-221. Short title. Sections 33-16-221 through 33-16-225 may be cited as the "Mature Defensive Driving Act".

History: En. Sec. 1, Ch. 49, L. 1987.

33-16-222. Requirement for rate reduction. (1) Any rates, rating schedules, or rating manuals for liability, bodily injury, or collision coverages of a motor vehicle insurance policy filed with the insurance department must provide for an appropriate premium reduction as determined by the insurer for an insured operator of a covered vehicle who is 55 years of age or older and who has successfully completed a highway traffic safety program as provided by 61-2-102 and 61-2-103.

(2) In addition to providing a premium reduction, an insurer may reimburse the fee for participating in the highway traffic safety program.

(3) The premium reduction used by the insurer is presumed appropriate unless credible data demonstrates otherwise.

History: En. Sec. 2, Ch. 49, L. 1987; amd. Sec. 11, Ch. 469, L. 2005.

33-16-223. Effective period of reduction. (1) The premium reduction required by 33-16-222 is effective for an insured for a 3-year period after successful completion of the approved course. Each person shall take an approved course every 3 years in order to continue to be eligible for the reduction in premium required by 33-16-222.

(2) An insurer may require, as a condition of maintaining the discount, any or all of the following:

(a) that the insured not be involved in an accident in which the insured is at fault;

(b) that the insured not be convicted of or plead guilty or nolo contendere to a moving traffic violation; or

(c) that the insured not have forfeited bail or collateral for a moving traffic violation.

History: En. Secs. 3, 6, Ch. 49, L. 1987; amd. Sec. 1201, Ch. 56, L. 2009; amd. Sec. 1, Ch. 111, L. 2019.

33-16-224. Certificate. The organization offering the approved course shall issue a certificate to each person who successfully completes the course that qualifies the person for the premium discount required by 33-16-222.

History: En. Sec. 4, Ch. 49, L. 1987; amd. Sec. 1202, Ch. 56, L. 2009.

33-16-225. When discount not applicable. The provisions of 33-16-222 do not apply if the approved course is taken as punishment specified by a court or other governmental entity for a moving traffic violation.

History: En. Sec. 5, Ch. 49, L. 1987.

33-16-226 through 33-16-229 reserved.

33-16-230. Rate reduction for military defensive drivers — effective period — exclusions. (1) (a) Any rates, rating schedules, or rating manuals for liability, bodily injury, or collision coverages of a motor vehicle insurance policy filed with the insurance department must provide for an appropriate premium reduction as determined by the insurer for a member of the Montana national guard who is an insured operator of a covered nonmilitary vehicle and who has successfully completed a defensive driving course referred to in 61-2-102(2).

(b) Any discount used by the insurer is presumed appropriate unless credible data demonstrates otherwise.

(2) The premium reduction required under subsection (1)(a) is effective for an insured for 3 years after successful completion of the approved course. Each person shall successfully complete a defensive driving course referred to in 61-2-102(2) every 3 years to remain eligible for the reduction provided in subsection (1)(a).

(3) Subsection (1)(a) does not apply if the approved course is taken as punishment specified by a court or other governmental entity for a moving traffic violation.

(4) An insurer may deny the discount under subsection (1)(a) if within 3 years prior to the insured's application for the rate reduction or during the period for which the rate reduction is provided:

(a) the insured was convicted of or plead guilty or nolo contendere to a moving traffic violation;

(b) the insured has forfeited bail or collateral for a moving traffic violation; or

(c) the insured was convicted by a court or found at fault in a motor vehicle accident.

History: En. Sec. 1, Ch. 576, L. 2005; amd. Sec. 2, Ch. 111, L. 2019.

33-16-231. Repealed. Sec. 1, Ch. 79, L. 1995.

History: En. Sec. 2, Ch. 400, L. 1989.

33-16-232. Repealed. Sec. 1, Ch. 79, L. 1995.

History: En. Sec. 3, Ch. 400, L. 1989.

33-16-233. Repealed. Sec. 1, Ch. 79, L. 1995.

History: En. Sec. 4, Ch. 400, L. 1989.

33-16-234. Repealed. Sec. 1, Ch. 79, L. 1995.

History: En. Sec. 5, Ch. 400, L. 1989.

33-16-235. Repealed. Sec. 1, Ch. 79, L. 1995.

History: En. Sec. 6, Ch. 400, L. 1989.

33-16-236. Repealed. Sec. 1, Ch. 79, L. 1995.

History: En. Sec. 7, Ch. 400, L. 1989.

Part 3
Insurers Acting in Concert

Part Cross-References

Unlawful price fixing, 30-14-205.

33-16-301. Insurers authorized to act in concert. Subject to and in compliance with the provisions of this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research.

History: En. Sec. 8, Ch. 362, L. 1969; R.C.M. 1947, 40-3641.

33-16-302. Insurers with common ownership or cosureties on bond — acting in concert. With respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research, two or more admitted insurers having a common ownership or operating in this state under common management or control are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer, and to the extent that such matters relate to cosurety bonds, two or more admitted insurers executing such bonds are hereby authorized to act in concert between or among themselves the same as if they constituted a single insurer.

History: En. Sec. 9, Ch. 362, L. 1969; R.C.M. 1947, 40-3642.

Cross-References

Suretyship, Title 28, ch. 11, part 4.

Workers' compensation rates and rating organizations, Title 33, ch. 16, part 10.

Workers' compensation, Title 39, ch. 71.

33-16-303. Use of rates, rating systems, underwriting rules, and policy or bond forms of rating or advisory organizations — agreements to adhere to. (1) Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules, or policy or bond forms of those organizations, either consistently or intermittently, but, except as provided in 33-16-105, 33-16-302, 33-16-305, 33-16-307, 33-16-1008, 33-16-1020 through 33-16-1023, and 33-16-1025 through 33-16-1036, may not agree with each other or rating organizations or others to adhere to the organizations' rates, systems, rules, or policy or bond forms.

(2) The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization or the underwriting rules or policy or bond forms prepared by a rating or advisory organization is not sufficient in itself to support a finding that an agreement prohibited under subsection (1) exists and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any agreement.

History: En. Sec. 10, Ch. 362, L. 1969; amd. Sec. 2, Ch. 558, L. 1977; R.C.M. 1947, 40-3643; amd. Sec. 19, Ch. 186, L. 1995; amd. Sec. 7, Ch. 320, L. 2015.

33-16-304. Exchange of information or experience data — consultation with rating organizations and insurers. Licensed rating organizations and admitted insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to ratemaking and the application of rating systems.

History: En. Sec. 11, Ch. 362, L. 1969; R.C.M. 1947, 40-3644.

33-16-305. Agreements for apportionment of casualty insurance — approval of commissioner — review of practices of adherents — revocation of approval. (1) Agreements may be made among admitted insurers with respect to the equitable apportionment among them of casualty insurance that may be afforded applicants who are in good faith entitled to but who are unable to procure the insurance through ordinary methods and with respect to the use of reasonable rate modifications for the insurance. The agreements are subject to the approval of the commissioner.

(2) All agreements must be submitted in writing to the commissioner for consideration and approval, together with information that the commissioner may reasonably require. The commissioner shall approve only agreements that are found to contemplate:

(a) the use of rates that meet the standards prescribed by this chapter; and

(b) activities and practices that are not unfair, unreasonable, or otherwise inconsistent with the provisions of this chapter.

(3) At any time after the agreements are in effect, the commissioner may review the practices and activities of the parties to the agreements and if, after a hearing upon not less than 10 days' notice to the parties, the commissioner finds that any practice or activity is unfair or unreasonable or is otherwise inconsistent with the provisions of this chapter, the commissioner may issue a written order to the parties to any agreement, specifying in what respects the act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter and requiring the discontinuance of the activity or practice. For good cause and after hearing upon not less than 10 days' notice to the parties, the commissioner may revoke approval of any agreement referred to in this section.

History: En. Sec. 12, Ch. 362, L. 1969; R.C.M. 1947, 40-3645; amd. Sec. 1203, Ch. 56, L. 2009.

Cross-References

Hearings by Commissioner, 33-1-701.

Casualty insurance — general provisions, Title 33, ch. 23.

33-16-306. Joint underwriters and reinsurers — compliance. Upon compliance with the provisions of this chapter applicable thereto, any rating organization, advisory organization, and any group, association, or other organization of admitted insurers which engages in joint underwriting or joint reinsurance through such organization or by standing agreement among the members thereof may conduct operations in this state. As respects insurance risks or operations in this state, no insurer shall be a member or subscriber of any such organization, group, or association that has not complied with the provisions of this chapter applicable to it.

History: En. Sec. 13, Ch. 362, L. 1969; R.C.M. 1947, 40-3646.

33-16-307. Joint underwriting and joint reinsurance — application — restrictions on operations. (1) Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance through such group, association, or organization or by standing agreement among the members thereof, shall file with the commissioner:

(a) a copy of its constitution, its articles of incorporation, agreement, or association, and of its bylaws and rules governing its activities, all duly certified by the custodian of the originals thereof;

(b) a list of its members; and

(c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process may be served.

(2) Every such group, association, or other organization shall notify the commissioner promptly of every change in its constitution, its articles of incorporation, agreement, or association, and its bylaws and rules governing the conduct of its business; its list of members; and the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such group, association, or organization may be served.

(3) No such group, association, or organization shall engage in any unfair or unreasonable practice with respect to such activities.

History: En. Sec. 20, Ch. 362, L. 1969; R.C.M. 1947, 40-3653.

Cross-References

Unfair trade practices, Title 33, ch. 18.

33-16-308. Advisory organizations — application — requisites — restrictions on operations. (1) No advisory organization shall conduct its operations in this state unless and until it has filed with the commissioner:

(a) a copy of its constitution, articles of incorporation, agreement, or association, and of its bylaws or rules governing its activities, all duly certified by the custodian of the originals thereof;

(b) a list of its members and subscribers; and

(c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process may be served.

(2) Every such advisory organization shall notify the commissioner promptly of every change in its constitution, its articles of incorporation, agreement, or association, and of its bylaws and rules governing the conduct of its business; its list of members and subscribers; and

the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such organization may be served.

(3) No such advisory organization shall engage in any unfair or unreasonable practice with respect to such activities.

History: **En. Sec. 19, Ch. 362, L. 1969; R.C.M. 1947, 40-3652.**

Cross-References

Unfair trade practices, Title 33, ch. 18.

Part 4
Rating Organizations

33-16-401. Rating organizations — compliance — application. (1) No rating organization shall conduct its operations in this state without first filing with the commissioner a written application for and securing a license to act as a rating organization. Any rating organization may make application for and obtain a license as a rating organization if it shall meet the requirements for license set forth in this chapter.

(2) Every such rating organization shall file with its application:

(a) a copy of its constitution, its articles of incorporation, agreement, or association, and of its bylaws and rules governing the conduct of its business, all duly certified by the custodian or the originals thereof;

(b) a list of its members and subscribers;

(c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served; and

(d) a statement of its qualifications as a rating organization.

History: **En. Sec. 14, Ch. 362, L. 1969; R.C.M. 1947, 40-3647.**

33-16-402. Evidence prerequisite to license. To obtain and retain a license, a rating organization shall provide satisfactory evidence to the commissioner that it will:

(1) permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination or withdraw therefrom;

(2) neither have nor adopt any rule or exact any agreement, the effect of which would be to require any member or subscriber, as a condition to membership or subscribership, to adhere to its rates, rating plans, rating systems, underwriting rules, or policy or bond forms;

(3) neither adopt any rule nor exact any agreement, the effect of which would be to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(4) neither practice nor sanction any plan or act of boycott, coercion, or intimidation;

(5) neither enter into nor sanction any contract or act by which any person is restrained from lawfully engaging in the insurance business;

(6) notify the commissioner promptly of every change in its constitution, its articles of incorporation, agreement, or association, and of its bylaws and rules governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such organization may be served;

(7) comply with the provisions of 33-16-105 and 33-16-203.

History: **En. Sec. 15, Ch. 362, L. 1969; R.C.M. 1947, 40-3648.**

33-16-403. Examination of application and investigation of applicant — issuance of license — fee. (1) The commissioner shall examine each application for a license to act as a rating or advisory organization pursuant to this part or a workers' compensation advisory organization pursuant to part 10 and the documents filed with the application and may make a further investigation of the applicant, its affairs, and its proposed plan of business as the commissioner considers appropriate.

(2) The commissioner shall issue the license applied for within 60 days of its filing if, from the examination and investigation, the commissioner is satisfied that:

(a) the business reputation of the applicant and its officers is good;

(b) the facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish; and

(c) the applicant and its proposed plan of operation conform to the requirements of this chapter.

(3) Otherwise, but only after a hearing upon notice, the commissioner shall, in writing, deny the application and notify the applicant of the decision and the reasons for the denial.

(4) The commissioner may grant an application in part only and issue a license to act as a rating, advisory, or workers' compensation advisory organization for one or more of the classes of insurance or subdivisions of the classes of insurance or class of risk, or a part or combination of a class of risk as are specified in the application, if the applicant qualifies for only a portion of the classes applied for.

(5) (a) Except as provided in subsection (5)(b), licenses issued pursuant to this section remain in effect until revoked as provided in this chapter. The fee for the license is $100 annually and must be deposited in the state special revenue fund to the credit of the state auditor's office.

(b) Each workers' compensation advisory organization is required to renew its license annually.

History: En. Sec. 16, Ch. 362, L. 1969; amd. Sec. 1, Ch. 206, L. 1973; R.C.M. 1947, 40-3649; amd. Sec. 20, Ch. 186, L. 1995; amd. Sec. 43, Ch. 227, L. 2001; amd. Sec. 19, Ch. 380, L. 2003.

Cross-References
Hearings by Commissioner, 33-1-701.

33-16-404. Rules governing eligibility for membership. Subject to the approval of the commissioner, licensed rating organizations may make reasonable rules governing eligibility for membership.

History: En. Sec. 17, Ch. 362, L. 1969; R.C.M. 1947, 40-3650.

33-16-405. Insurers with common ownership or management. If two or more insurers having a common ownership or operating in this state under common management are admitted for the classes or types of insurance for which a rating organization is licensed to make rates, the rating organization may require as a condition to membership or subscribership of one or more that all such insurers shall become members or subscribers.

History: En. Sec. 18, Ch. 362, L. 1969; R.C.M. 1947, 40-3651.

Parts 5 through 9 reserved

Part 10

Workers' Compensation Rates and Advisory Organizations

33-16-1001. Declaration of policy and purpose. (1) It is declared that the public welfare is served by the making of advisory premium rates for workers' compensation insurance coverage in concert.

(2) It is the purpose of this part to:

(a) authorize such ratemaking in concert and the operating of rating organizations thereto; and

(b) establish the general bases and standards for the making of such rates.

History: En. Sec. 1, Ch. 329, L. 1969; amd. Sec. 3, Ch. 558, L. 1977; R.C.M. 1947, 40-5601.

33-16-1002. Applicability of part. This part, together and in conjunction with parts 1 through 4 of this chapter, applies to the making of premium rates for workers' compensation insurance issued under compensation plan No. 2 and plan No. 3 of the Workers' Compensation Act, Title 39, chapter 71, part 22 and part 23, respectively, or related employer's liability insurance, but does not apply to reinsurance.

History: En. Sec. 2, Ch. 329, L. 1969; amd. Sec. 4, Ch. 558, L. 1977; R.C.M. 1947, 40-5602; amd. Sec. 21, Ch. 186, L. 1995; amd. Sec. 8, Ch. 320, L. 2015.

33-16-1003. Certain reciprocal insurers excluded. This part shall not apply as to any reciprocal insurer transacting workers' compensation insurance only and insuring solely the hazards or perils of its subscribers exclusively associated with a single industry.

History: En. Sec. 3, Ch. 329, L. 1969; R.C.M. 1947, 40-5603.

Cross-References
Reciprocal insurers — general provisions, Title 33, ch. 5, part 1.

33-16-1004. Repealed. Sec. 29, Ch. 186, L. 1995.

History: En. Secs. 4, 5, 6, Ch. 329, L. 1969; R.C.M. 1947, 40-5604, 40-5605, 40-5606; amd. Sec. 1, Ch. 480, L. 1991.

33-16-1005. Repealed. Sec. 29, Ch. 186, L. 1995.

History: En. Sec. 16, Ch. 329, L. 1969; amd. Sec. 5, Ch. 558, L. 1977; R.C.M. 1947, 40-5616; amd. Sec. 3, Ch. 232, L. 1987; amd. Sec. 53, Ch. 613, L. 1989; amd. Sec. 14, Ch. 630, L. 1993.

33-16-1006. Repealed. Sec. 5, Ch. 114, L. 1981.

History: En. Sec. 17, Ch. 329, L. 1969; R.C.M. 1947, 40-5617.

33-16-1007. Renumbered 33-16-1011. Code Commissioner, 1981.

33-16-1008. Definitions. As used in this part, the following definitions apply:

(1) "Accepted actuarial standards" means the standards adopted by the casualty actuarial society in its Statement of Principles Regarding Property and Casualty Insurance Ratemaking and the Standards of Practice adopted by the actuarial standards board.

(2) (a) "Advisory organization" means a person or organization that either has two or more member insurers or is controlled either directly or indirectly by two or more insurers and that assists insurers in ratemaking-related activities.

(b) The term does not include a joint underwriting association, any actuarial or legal consultant, or any employee of an insurer or insurers under common control or management or their employees or manager. For the purposes of this subsection (2)(b), two or more insurers who have a common ownership or operate in this state under common control or management constitute a single insurer.

(3) "Classification system" means the plan, system, or arrangement for recognizing differences in exposure to hazards among industries, occupations, or operations of insurance policyholders.

(4) "Contingencies" means provisions in rates to recognize the uncertainty of the estimates of losses, loss adjustment expenses, other operating expenses, and investment income and profit that comprise those rates. The provisions may be explicit, including but not limited to a specific charge to reflect systematic variations of estimated costs from expected costs, or implicit, including but not limited to a consideration in selecting a single estimate from a reasonable range of estimates, or both.

(5) "Developed losses" means adjusted losses, including loss adjustment expenses, using accepted actuarial standards to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss payments, including loss adjustment expense payments.

(6) "Expenses" means the portion of a rate that is attributable to acquisition, filed supervision and collection expenses, general expenses and taxes, licenses, or fees.

(7) "Experience rating" means a rating procedure using past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder's loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

(8) "Insurer" means a person licensed to write workers' compensation insurance as a plan No. 2 insurer or plan No. 3, the state fund, under the laws of the state.

(9) "Loss trending" means a procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective, including loss ratio trending.

(10) "Market" means the interaction in this state between buyers and plan No. 2 sellers of workers' compensation and employer's liability insurance pursuant to the provisions of this part.

(11) (a) "Prospective loss costs" means historical aggregate losses and loss adjustment expenses, including all assessments that are loss-based and excluding any separately stated policyholder surcharges, projected through development to their ultimate value and through trending to a future point in time and ascertained by accepted actuarial standards.

(b) The term does not include provisions for profit or expenses other than loss adjustment expenses and assessments that are loss-based.

(12) "Pure premium rate" means the portion of the rate that represents the loss cost per unit of exposure, including loss adjustment expense.

(13) (a) "Rate" or "rates" means rate of premium, policy and membership fee, or any other charge made by an insurer for or in connection with a contract or policy of workers' compensation and employer's liability insurance, prior to application of individual risk variations based on loss or expense considerations.

(b) The term does not include minimum premiums.

(14) "Reserve estimates" means provisions for insurer obligations for future payments of loss or loss adjustment expenses.

(15) "Statistical plan" means the plan, system, or arrangement that is used in collecting data.

(16) "Supplementary rate information" means a manual or plan of rates, statistical plan, classification system, minimum premium, policy fee, rating rule, rate-related underwriting rule, and any other information needed to determine the applicable premium for an individual insured that is consistent with the purposes of this part and with rules prescribed by rule of the commissioner.

(17) "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied on by the filer, the interpretation of any statistical data relied on by the filer, descriptions of methods used in making the rates, and any other similar information required to be filed by the commissioner.

History: En. Sec. 1, Ch. 186, L. 1995; amd. Sec. 2, Ch. 284, L. 1997; amd. Sec. 9, Ch. 320, L. 2015.

33-16-1009 and 33-16-1010 reserved.

33-16-1011. Classification review committee — membership — term. (1) There is a classification review committee.

(2) The committee is composed of five voting members, consisting of:

(a) two representatives of private insurance carriers writing workers' compensation insurance in Montana. The members must be appointed by the Montana commissioner of insurance.

(b) one licensed independent insurance producer who resides in Montana, appointed by the commissioner of insurance;

(c) one representative of the state compensation insurance fund who is an employee of the state fund and who is appointed by the executive director of the state fund; and

(d) one representative of an employer who is insured by either a private insurance carrier or the state compensation insurance fund, appointed by the commissioner of insurance.

(3) Each member shall hold office for a period of 3 years. An appointee who fills the vacancy of a member whose term has not expired shall fill only the remaining term and may be reappointed for a full term.

(4) Before appointments are to be made by the commissioner of insurance under subsections (2)(a), (2)(b), and (2)(d), established private organizations representing insurance carriers, independent insurance producers, and employers may submit names of individuals they recommend for appointments. The commissioner of insurance shall consider the names submitted before appointments are made. However, the commissioner of insurance is not required to appoint any person from the names submitted.

(5) The committee must be staffed by the advisory organization designated under 33-16-1023 and be funded by the advisory organization. Committee members may, if they request, be paid their actual and necessary travel expenses.

(6) Documents and other information concerning the committee's actions must be made available for public review in the office of the commissioner of insurance.

History: En. Sec. 18, Ch. 329, L. 1969; amd. Sec. 6, Ch. 558, L. 1977; R.C.M. 1947, 40-5618; amd. Sec. 1, Ch. 114, L. 1981; MCA 1979, 33-16-1007; redes. 33-16-1011 by Code Commissioner, 1981; amd. Sec. 54, Ch. 613, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1, Ch. 528, L. 1993; amd. Sec. 14, Ch. 630, L. 1993; amd. Sec. 22, Ch. 186, L. 1995; amd. Sec. 2, Ch. 290, L. 1995.

33-16-1012. Functions and powers of classification review committee — hearings — rulemaking. (1) The classification review committee shall:

(a) meet not less than semiannually to conduct its business;

(b) make the final determination regarding the establishment or revision of all classifications in accordance with the procedures set forth in Title 2, chapter 4, part 3;

(c) publish material and pamphlets as it considers appropriate;

(d) act as a review committee concerning objections filed by a policyholder or insurer in relation to classifications assigned to a policyholder according to rules governing the issuance or application of classifications; and

(e) make rules as may be necessary for the conduct of any business that is subject to notice and hearings. The rules must be published and adopted as provided in Title 2, chapter 4, part 3, and must be published in the Administrative Rules of Montana as part of the rules promulgated by the commissioner of insurance.

(2) (a) The initial hearing conducted by the committee pursuant to subsection (1)(d) must be informal and nonbinding upon the parties and must be conducted pursuant to rules of procedure that the committee considers to be appropriate. The committee shall issue its written advisory decision within 30 days of the conclusion of the hearing and send a written copy of the decision by first-class mail, postage prepaid, to each party. Each party to the informal hearing shall notify the committee and each other party of the notifying party's intent to be bound or not bound by the committee's advisory decision, and the notice must be made within 30 days of the date the committee mails the written copy of the decision to the parties.

(b) A party who is aggrieved by the advisory decision of the committee, or by the refusal of a party to be bound by the committee's advisory decision rendered after a hearing conducted pursuant to subsection (2)(a) may, within 30 days after the expiration of the 30-day notice deadline specified in subsection (2)(a), initiate an informal contested case proceeding pursuant to 2-4-604 before the committee, and the committee shall hear the matter in a de novo administrative proceeding as provided in Title 2, chapter 4, part 6. The committee may, in its discretion or at the request of any party, appoint a hearings examiner. If a hearings examiner is appointed, the examiner shall take evidence and prepare proposed findings of fact and conclusions of law that the committee may accept, reject, or modify, in whole or in part, based on the evidence produced during the informal contested case proceeding.

(c) A party who is aggrieved by a decision of the committee rendered after a hearing conducted pursuant to subsection (2)(b) may petition the workers' compensation court for judicial review of the decision pursuant to Title 2, chapter 4, part 7.

(3) The committee is subject to the provisions of Title 2, chapter 3, parts 1 and 2.

History: **En. Sec. 2, Ch. 114, L. 1981; amd. Sec. 2, Ch. 528, L. 1993; amd. Sec. 23, Ch. 186, L. 1995; amd. Sec. 3, Ch. 290, L. 1995.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-16-1013 through 33-16-1019 reserved.

33-16-1020. Competitive market — hearing. (1) A competitive market is presumed to exist unless the commissioner, after hearing, issues an order stating that a reasonable degree of competition does not exist in the market. The order may not expire later than 1 year after issuance.

(2) In determining whether a reasonable degree of competition exists, the commissioner shall consider the following factors:

(a) the number of insurers actively engaged in providing coverage;

(b) market shares and changes in market shares;

(c) ease of entry into the market;

(d) market concentration among plan No. 2 insurers as measured by the Herfindahl-Hirschman index;

(e) whether long-term profitability for insurers in the market is unreasonably high in relation to the risks being insured;

(f) whether long-term profitability for insurers in the market is reasonable in relation to industries of comparable business risks; and

(g) generally accepted and relevant tests relating to competitive market structure, market performance, and market conduct.

(3) The workers' compensation insurance market may not be determined to be noncompetitive if the market concentration of the 50 largest insurers writing workers' compensation insurance under plan No. 2 satisfied the U.S. department of justice merger guidelines for an unconcentrated market.

(4) The commissioner's determinations must be made on the basis of findings of fact and conclusions of law.

History: **En. Sec. 2, Ch. 186, L. 1995.**

33-16-1021. Ratemaking standards — review by commissioner. (1) Rates may not be excessive, inadequate, or unfairly discriminatory.

(2) (a) Except as provided in subsection (2)(b), rates in a competitive market are not excessive. Rates in a noncompetitive market are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to services rendered.

(b) Rates for the state fund may not be determined to be excessive unless the rate clearly is likely to produce an excess of assets over what is reasonably necessary to pay developed losses, contingencies, expenses, and a reasonable level of surplus.

(3) A rate may not be determined to be inadequate unless:

(a) the rate is clearly insufficient to sustain projected losses and expenses;

(b) the rate is unreasonably low and the use of the rate by the insurer has had or, if continued, will tend to create a monopoly in the market; or

(c) funds equal to the full, ultimate cost of anticipated losses and loss adjustment expenses are not produced when prospective loss costs are applied to anticipated payrolls.

(4) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with different loss exposures or expense levels.

(5) In determining whether rates comply with standards under subsection (1), consideration must be given to:

(a) past and prospective loss experience within and outside Montana, in accordance with accepted actuarial principles;

(b) catastrophe hazards and contingencies;

(c) past and prospective expenses within and outside Montana;

(d) loadings for leveling premium rates over time for dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(e) a reasonable margin for underwriting profit; and

(f) all other relevant factors within and outside Montana.

(6) The systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of any other insurer or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

(7) The rate may contain provisions of contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of a profit, consideration must be given to all investment income attributable to premiums and the reserves associated with those premiums.

(8) The commissioner may investigate and determine whether rates in Montana are excessive, inadequate, or unfairly discriminatory. In any investigation and determination, the commissioner shall also consider the factors specified in 33-16-1020.

History: En. Sec. 3, Ch. 186, L. 1995; amd. Sec. 29, Ch. 472, L. 1999; amd. Sec. 10, Ch. 320, L. 2015.

33-16-1022. Dividends — regulation or prohibition. (1) An advisory organization may not adopt a rule that would regulate or prohibit the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

(2) A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers is not a rating plan or system. A plan for the payment of dividends, savings, or unabsorbed premium deposits does not relieve an insurer from complying with any requirement of this chapter regarding rating plans or systems.

(3) It is an unfair trade practice under 33-18-1003 to make the payment of a dividend or any portion of it conditioned upon renewal of the policy or contract.

History: En. Sec. 4, Ch. 186, L. 1995; amd. Sec. 30, Ch. 472, L. 1999.

33-16-1023. Membership in advisory organization. (1) The commissioner shall designate one workers' compensation advisory organization to assist the commissioner in gathering, compiling, and reporting relevant statistical information. Each workers' compensation insurer shall record and report its workers' compensation experience to the designated advisory organization as set forth in the uniform statistical plan approved by the commissioner.

(2) Each workers' compensation insurer must be a member or subscriber of the designated workers' compensation advisory organization. Each workers' compensation insurer may adhere to the policy forms filed by the advisory organization.

(3) Each workers' compensation insurer shall adhere to a uniform classification system and uniform experience rating plan that has been filed by the designated advisory organization with the commissioner and approved by the commissioner.

(4) Each workers' compensation insurer shall use the forms and adhere to the rules that the designated advisory organization shall develop and file with the commissioner. The forms and rules must be reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, the uniform experience rating plan, and the uniform classification system.

(5) The methodology of the experience rating plan required under subsection (3) must be based on:

(a) reasonable eligibility standards;

(b) incentives for loss prevention; and

(c) a premium differential to encourage safety.

(6) The designated advisory organization or an insurer may file rating plans with the commissioner that provide for prospective or retrospective premium adjustment based on an insured's expected or actual loss experience, including but not limited to scheduled rating adjustments, retrospective rating plans, optional deductible plans under 39-71-435, a construction industry premium credit plan under 39-71-2211, or other plans as authorized by statute or approved by the commissioner.

History: En. Sec. 5, Ch. 186, L. 1995.

33-16-1024. Repealed. Sec. 22, Ch. 320, L. 2015.

History: En. Sec. 6, Ch. 186, L. 1995; amd. Sec. 5, Ch. 276, L. 1997.

33-16-1025. Interchange of rating plan — data exchange — cooperative action in ratemaking — violation of part. (1) Reasonable rules and plans may be adopted by the commissioner for the interchange of data necessary for the application of rating plans.

(2) To ensure conformity in administering rate regulatory laws, the commissioner, each insurer, and the advisory organization designated by the commissioner may exchange information and experience data with insurance regulatory officials, insurers, and advisory organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

(3) Cooperation among advisory organizations or among insurers and advisory organizations in ratemaking or in other matters within the scope of this part is authorized, but the filings resulting from the cooperation are subject to all provisions of this part.

(4) The commissioner may review the cooperative activities and practices. If, after hearing, any cooperative activity or practice is found to violate the provisions of this part, a written order may be issued specifying that the activity or practice violates the provision of this part and requiring the discontinuance of the activity or practice.

History: En. Sec. 7, Ch. 186, L. 1995.

33-16-1026. Rate filings. (1) A workers' compensation advisory organization shall file with the commissioner:

(a) workers' compensation rates and rating plans that are limited to prospective loss costs;

(b) each workers' compensation policy form to be used by its members or subscribers;

(c) the uniform classification plan and rules of the advisory organization;

(d) the uniform experience rating plan and rules of the advisory organization; and

(e) any other information that the commissioner requests and is entitled to receive under this part.

(2) Each insurer shall file with the commissioner all rates, supplementary rate information, and any changes and amendments made by it for use in this state as required by the commissioner under 33-16-1027(2).

(3) An insurer may establish rates and supplementary rate information based upon the factors in 33-16-1021. An insurer may adopt by reference, with or without deviation, the prospective loss costs filed by the advisory organization designated under 33-16-1023 or the rates and supplementary rate information filed by another insurer.

(4) An insurer may not make or issue a contract or policy of insurance under this part, except in accordance with the filings that are in effect for the insurer as provided in this part.

(5) In addition to other prohibitions in this part, an advisory organization may not file rates, supplementary rate information, or supporting information on behalf of an insurer.

(6) If each rate in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer is not lower than the prospective loss costs contained in the schedule of workers' compensation rates for those classifications filed by the designated advisory organization under subsection (1), the schedule of rates filed by the insurer is not subject to 33-16-1027(1) but becomes effective upon filing.

History: **En. Sec. 8, Ch. 186, L. 1995; amd. Sec. 146, Ch. 42, L. 1997.**

33-16-1027. Rate filing review. (1) The commissioner shall review each insurance filing to ensure compliance with the following guidelines:

(a) The effective date of each workers' compensation insurer or advisory organization filing must be the date specified in the filing. The effective date of the filing may not be earlier than 30 days after the date on which the filing is received by the commissioner or the date of receipt of the information furnished in support of the filing, if the supporting information is required by the commissioner.

(b) Upon written application of the insurer or advisory organization, the commissioner may authorize a filing that becomes effective before the expiration of the period described in subsection (1)(a).

(c) A filing is considered to have met the requirements of this part unless disapproved by the commissioner within the period described in subsection (1)(a) or any extension of the period.

(2) Whenever a filing is not accompanied by the information required under this section, the commissioner shall inform the filer of the deficiency within 30 days of the initial filing. The filing is considered made when the required information is furnished or when the filer certifies to the commissioner that the additional information requested by the commissioner is not maintained or cannot be provided.

History: **En. Sec. 9, Ch. 186, L. 1995; amd. Sec. 23, Ch. 531, L. 1997.**

33-16-1028. Improper rates — hearing. (1) If the commissioner finds that a rate is not in compliance with 33-16-1021 or that a rate has been set in violation of 33-16-1032, the commissioner shall order that its use be discontinued for any policy issued or renewed after the date of the order, and the order may prospectively provide for premium adjustment of any policy then in force.

(2) The order must be issued within 30 days after the close of a hearing, if one is requested by the insurer, or within a reasonable time fixed by the commissioner. The order expires 1 year after its effective date unless rescinded earlier by the commissioner.

(3) If the commissioner disapproves a rate under subsection (1), disapproval must take effect not less than 15 days after the commissioner's order and the last previous rate in effect for the insurer must be reimposed for a period of 1 year unless the commissioner approves a rate under the provisions of subsection (5) or (6).

(4) A determination made by the commissioner under this section must be in accordance with accepted actuarial standards on the basis of findings of fact and conclusions of law.

(5) For a period of 1 year after the effective date of a disapproval order under subsection (1), a rate adopted to replace one disapproved under the order may not be used until it has been filed with the commissioner and approved within 30 days.

(6) Whenever an insurer does not have legally effective rates pursuant to subsection (1), the commissioner shall, on the insurer's request, specify interim rates for the insurer that are adequate to protect the interests of all parties. The commissioner may order that a specified portion of the premiums be placed in a special reserve established by the insurer. When new rates become legally effective, the commissioner shall order the reserved funds or any overcharge in the interim rates to be distributed appropriately, except that minimal adjustments may not be required.

History: **En. Sec. 10, Ch. 186, L. 1995.**

33-16-1029. Restrictions on certain insurers — waiting period. (1) The commissioner may require that a particular insurer file any of its rates and supplementary rate information 30 days prior to the effective date of the rates, if the commissioner finds after a hearing that the protection of the interests of the insurer's insureds and the public in this state requires closer supervision of the insurer's rates.

(2) Upon written application by an insurer, the commissioner, following review, may authorize a filing, which is effective before the expiration of the period described in subsection (1).

(3) The filing must be approved or disapproved during the waiting period and, if not disapproved before the expiration of the waiting period, is considered to have met the requirements of this section.

(4) An insurer aggrieved by the commissioner's actions under this section may request a rehearing by the commissioner after the expiration of 12 months from the date of the commissioner's initial order.

History: En. Sec. 11, Ch. 186, L. 1995.

33-16-1030. Delay of rates in noncompetitive market. (1) A 30-day waiting period may be implemented or extended under one of the following circumstances:

(a) after finding that the market is not competitive under 33-16-1020, the commissioner adopts a rule requiring that any subsequent changes in rates or supplementary information must be filed with the commissioner at least 30 days before the changes become effective;

(b) the commissioner extends the waiting period under this section for a period not exceeding 30 additional days by written notice to the filer before the first 30-day period expires;

(c) upon written application by an insurer or advisory organization, the commissioner, following review, authorizes a filing, which becomes effective before the expiration of the period described in subsection (1)(a) or (1)(b); or

(d) the filing is approved or disapproved during the waiting period and, if not disapproved before the expiration of the waiting period, is considered to have met the requirements of this section.

(2) If a rule is adopted under subsection (1), the commissioner may require the filing of supporting data as to classes of risks or combinations of risk classes that the commissioner considers necessary for the proper functioning of the rate monitoring and regulating process. The supporting data must include:

(a) the experience and judgment of the filer and, to the extent that the filer wishes or the commissioner requires, the experience and judgment of other insurers or the advisory organization designated under 33-16-1023;

(b) the interpretation of any statistical data upon which the filer relied;

(c) a description of the actuarial and statistical methods used in setting the rate; and

(d) any other relevant matter required by the commissioner.

(3) A rule adopted under this section expires 1 year after adoption unless renewed by the commissioner after hearings and appropriate findings under this section.

(4) Whenever a filing is not accompanied by the information that the commissioner has required under subsection (2), the commissioner shall inform the insurer within 10 days of the initial filing. The filing is considered made when the required information is furnished.

History: En. Sec. 12, Ch. 186, L. 1995.

33-16-1031. Consent to rate. Notwithstanding any other provision of this part, upon the written consent of the insured, filed with the commissioner, a rate in excess of that determined in accordance with the other provisions of this part may be used on any specific risk.

History: En. Sec. 13, Ch. 186, L. 1995.

33-16-1032. Acts reducing competition prohibited. (1) In this section, the word "insurer" includes two or more affiliated insurers engaged in joint or cooperative underwriting, investment management, marketing, servicing, or administration of their business and affairs as insurers and:

(a) under common management; or

(b) under common controlling ownership or under other common effective legal control.

(2) An insurer or advisory organization may not:

(a) monopolize or attempt to monopolize or combine or conspire with any other person or persons to monopolize the business of insurance of any kind, subdivision, or class;

(b) agree with any other insurer or advisory organization to charge or adhere to any rate or rating plan other than the uniform experience rating plan or rating rules of the advisory organization, except as needed to comply with the requirements of 33-16-1026;

(c) make an agreement with any other insurer, advisory organization, or other person to unreasonably restrain trade or substantially lessen competition in the business of insurance of any kind, subdivision, or class; or

(d) make an agreement with any other insurer or advisory organization to refuse to deal with any person in connection with the sale of insurance.

(3) The fact that two or more insurers, whether they are members or subscribers of a common advisory organization, use consistently or intermittently the same advisory organization rules or insurer guidelines, rating plans, rating schedules, rating rules, policy forms, rate classifications, underwriting rules, surveys, or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

(4) An advisory organization or member or subscriber of an advisory organization may not interfere with the right of any insurer to establish its rates independently of that advisory organization or to charge rates different from the rates made by that advisory organization.

(5) Except as required by 33-16-1026, an advisory organization may not have or adopt any rule or exact any agreement or formulate or engage in any program that would require any member, subscriber, or other insurer to:

(a) adhere to its rates; or

(b) prevent any insurer from acting independently.

History: **En. Sec. 14, Ch. 186, L. 1995.**

33-16-1033. Advisory organization — permitted activity. An advisory organization may:

(1) develop statistical plans, including class definitions;

(2) collect statistical data from members, subscribers, or any other source;

(3) prepare and distribute pure premium rate data, adjusted for loss development and loss trending, in accordance with its statistical plan. The data and adjustments must be in sufficient detail to permit insurers to modify pure premiums based upon their own rating methods or interpretations of underlying data.

(4) prepare and distribute manuals for rating rules and rating schedules that do not contain any rules or schedules, including final rates, without information outside the manuals;

(5) distribute information that is filed with the commissioner and open to public inspection;

(6) conduct research and collect statistics in order to discover, identify, and classify information relating to causes or prevention of losses;

(7) prepare and file policy forms and endorsements and consult with members, subscribers, and others relative to their use and application;

(8) collect, compile, and distribute past and current prices of individual insurers, if the information is made available to the general public;

(9) conduct research and collect information to determine the impact of benefit level changes on pure premium rates;

(10) prepare and distribute rules and rating values for the uniform experience rating plan; and

(11) calculate and disseminate individual risk premium modification factors. Individual risk premium modification factors may only be disseminated to:

(a) a licensed producer or an insurer for the business of insurance only; and

(b) the department of labor and industry for regulatory purposes only. Individual employer payroll and loss information may be provided to a person other than the current licensed producer or an insurer only after obtaining the employer's written permission.

History: **En. Sec. 15, Ch. 186, L. 1995; amd. Sec. 11, Ch. 320, L. 2015.**

33-16-1034. Advisory organization — prohibited activity. In addition to other prohibitions in this part, except as specifically permitted under 33-16-1033, an advisory organization may not compile or distribute recommendations relating to rates that include expenses, other than loss adjustment expenses, or profit.

History: En. Sec. 16, Ch. 186, L. 1995.

33-16-1035. Penalties — suspension of license. (1) The commissioner may impose upon a person or organization that violates 33-16-1020 through 33-16-1023 or 33-16-1025 through 33-16-1036 a penalty of not more than $500 for each violation.

(2) If the commissioner determines that the violation is willful, the commissioner may impose a penalty of not more than $1,000 for each violation in addition to any other penalty provided by law.

(3) The commissioner may suspend the license of an insurer or an advisory organization that fails to comply with any order within the time set by the order or extension granted by the commissioner. The commissioner may not suspend a license for failure to comply with an order until the time prescribed for appeal from the order has expired or, if appealed, until the order has been affirmed. The commissioner may determine the period of a suspension, which remains in effect for the period unless modified or rescinded or until the order upon which the suspension is based is modified, rescinded, or reversed.

(4) Unless a consent decree has been entered, a penalty may not be imposed nor may a license be suspended or revoked unless the commissioner, following a hearing, issues a written order with findings of fact. The hearing must be held at least 10 days after written notice to the person or organization specifying the alleged violation.

(5) A party aggrieved by an order or decision of the commissioner may, within 30 days after receiving the commissioner's notice, make a written request for a hearing.

History: En. Sec. 17, Ch. 186, L. 1995; amd. Sec. 147, Ch. 42, L. 1997; amd. Sec. 12, Ch. 320, L. 2015.

33-16-1036. Appeals from commissioner. (1) An order, decision, or act of the commissioner under this part may be appealed to district court upon petition of a person aggrieved.

(2) A petition for review must be filed within 60 days from notice of the order, decision, or act. The commencement of the proceeding does not affect enforcement or validity of the commissioner's action unless the court determines, after notice to the commissioner, that a stay of enforcement until further direction of the court will not injure the interests of the public.

History: En. Sec. 18, Ch. 186, L. 1995.

CHAPTER 17

INSURANCE PRODUCERS, ADJUSTERS, CONSULTANTS, AND ADMINISTRATORS

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Chapter Cross-References

Agency generally, Title 28, ch. 10.

Part 1
General Provisions

33-17-101. Scope of chapter. (1) The purpose of this chapter is to govern the qualifications and procedures for licensing insurance producers.

(2) Except as provided in subsection (3), this chapter applies to all stock, mutual, and reciprocal insurers and to all kinds of insurance and annuities.

(3) Except as provided in 33-17-401 and 33-17-408(2), this chapter does not apply to surplus lines producers.

History: En. Sec. 145, Ch. 286, L. 1959; R.C.M. 1947, 40-3301; amd. Sec. 17, Ch. 713, L. 1989; amd. Sec. 2, Ch. 106, L. 2001.

33-17-102. Definitions. As used in this chapter, the following definitions apply:

(1) (a) "Adjuster" means a person who, on behalf of the insurer, for compensation as an independent contractor or as the employee of an independent contractor or for a fee or commission investigates and negotiates the settlement of claims arising under insurance contracts or otherwise acts on behalf of the insurer.

(b) The term does not include a:

(i) licensed attorney who is qualified to practice law in this state;

(ii) salaried employee of an insurer or of a managing general agent;

(iii) licensed insurance producer who adjusts or assists in adjustment of losses arising under policies issued by the insurer;

(iv) licensed third-party administrator who adjusts or assists in adjustment of losses arising under policies issued by the insurer; or

(v) claims examiner as defined in 39-71-116.

(2) "Adjuster license" means a document issued by the commissioner that authorizes a person to act as an adjuster or a public adjuster.

(3) (a) "Administrator" means a person who collects charges or premiums from residents of this state in connection with life, disability, property, or casualty insurance or annuities or who adjusts or settles claims on these coverages.

(b) The term does not include:

(i) an employer on behalf of its employees or on behalf of the employees of one or more subsidiaries of affiliated corporations of the employer;

(ii) a union on behalf of its members;

(iii) (A) an insurer that is either authorized in this state or acting as an insurer with respect to a policy lawfully issued and delivered by the insurer in and pursuant to the laws of a state in which the insurer is authorized to transact insurance; or

(B) a health service corporation as defined in 33-30-101;

(iv) a pharmacy benefit manager as defined in 33-2-2402 that is licensed pursuant to 33-2-2403;

(v) a life, disability, property, or casualty insurance producer who is licensed in this state and whose activities are limited exclusively to the sale of insurance;

(vi) a creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vii) a trust established in conformity with 29 U.S.C. 186 or the trustees, agents, and employees of the trust;

(viii) a trust exempt from taxation under section 501(a) of the Internal Revenue Code or the trustees and employees of the trust;

(ix) a custodian acting pursuant to a custodian account that meets the requirements of section 401(f) of the Internal Revenue Code or the agents and employees of the custodian;

(x) a bank, credit union, or other financial institution that is subject to supervision or examination by federal or state banking authorities;

(xi) a company that issues credit cards and that advances for and collects premiums or charges from the company's credit card holders who have authorized the company to do so, if the company does not adjust or settle claims;

(xii) a person who adjusts or settles claims in the normal course of the person's practice or employment as an attorney and who does not collect charges or premiums in connection with life or disability insurance or annuities; or

(xiii) a person appointed as a managing general agent in this state whose activities are limited exclusively to those described in 33-2-1501(10) and Title 33, chapter 2, part 16.

(4) (a) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(b) The term does not include an individual.

(5) "Consultant" means an individual who for a fee examines, appraises, reviews, evaluates, makes recommendations, or gives advice regarding an insurance policy, annuity, or pension contract, plan, or program.

(6) "Consultant license" means a document issued by the commissioner that authorizes an individual to act as an insurance consultant.

(7) "Exchange" means a health benefit exchange established by the state of Montana or an exchange established by the United States department of health and human services in accordance with 42 U.S.C. 18031.

(8) "Home state" means the District of Columbia or any state or territory of the United States in which a person licensed under this chapter maintains a principal place of residence or a principal place of business.

(9) "Individual" means a natural person.

(10) "Insurance producer", except as provided in 33-17-103, means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(11) "Lapse" means the expiration of the license for failure to renew by the biennial renewal date.

(12) "License" means a document issued by the commissioner that authorizes a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create actual, apparent, or inherent authority in the holder to represent or commit an insurer to a binding agreement.

(13) "Limited line credit insurance" includes credit life insurance, credit disability insurance, credit property insurance, credit unemployment insurance, involuntary unemployment insurance, mortgage life insurance, mortgage guaranty insurance, mortgage disability insurance, gap insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing the credit obligation and that the commissioner determines should be designated as a form of limited line credit insurance.

(14) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

(15) "Limited lines insurance" means those lines of insurance that the commissioner finds necessary to recognize for the purposes of complying with 33-17-401(3).

(16) "Limited lines producer" means a person authorized by the commissioner to sell, solicit, or negotiate limited lines insurance.

(17) "Lines of authority" means any kind of insurance as defined in Title 33.

(18) "Navigator" means a person certified by the commissioner under 33-17-241 and selected to perform the activities and duties identified in 42 U.S.C. 18031, et seq.

(19) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract if the person engaged in negotiation either sells insurance or obtains insurance from insurers for purchasers.

(20) "Person" means an individual or a business entity.

(21) (a) "Public adjuster" means an adjuster retained by and representing the interests of the insured.

(b) The term does not include a person who provides an estimate of work to an insurer on behalf of an insured as long as the insured is notified of all communications between the person and the insurer related to the estimates.

(22) "Sell" means to exchange a contract of insurance by any means, for money or the equivalent, on behalf of an insurance company.

(23) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance.

(24) "Suspend" means to bar the use of a person's license for a period of time.

History: En. Secs. 146, 147, 148, 150, Ch. 286, L. 1959; R.C.M. 1947, 40-3302, 40-3303(part), 40-3304, 40-3306; amd. Sec. 5, Ch. 518, L. 1983; amd. Sec. 1, Ch. 409, L. 1987; amd. Sec. 18, Ch. 713, L. 1989; amd. Sec. 25, Ch. 798, L. 1991; amd. Sec. 49, Ch. 379, L. 1995; amd. Sec. 24, Ch. 531, L. 1997; amd. Sec. 3, Ch. 106, L. 2001; amd. Sec. 10, Ch. 427, L. 2003; amd. Sec. 1, Ch. 140, L. 2005; amd. Sec. 12, Ch. 469, L. 2005; amd. Sec. 4, Ch. 313, L. 2009; amd. Sec. 11, Ch. 169, L. 2013; amd. Sec. 6, Ch. 245, L. 2013; amd. Sec. 3, Ch. 139, L. 2015; amd. Sec. 17, Ch. 151, L. 2017; amd. Sec. 13, Ch. 501, L. 2021.

33-17-103. Exemptions from definition of insurance producer. The definition of insurance producer does not include:

(1) an individual who is a regularly salaried officer or employee of an insurer and who is engaged in the performance of usual and customary executive, administrative, or clerical duties and whose duties do not include the negotiation, sale, or solicitation of insurance;

(2) an individual who is a salaried employee in the office of an insurance producer and who devotes the individual's full time to clerical and administrative services, including the incidental taking of insurance applications and receipt of premiums in the office of the individual's employer, if the individual does not receive any commissions on the applications and the individual's compensation is not varied by the volume of applications or premiums the individual takes or receives;

(3) a person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, or group or blanket accident and disability insurance or for the purpose of enrolling individuals under those plans, issuing certificates under those plans, or otherwise assisting in administering those plans if a commission is not paid for the service;

(4) an employer, the employer's officers or employees, or the trustees of an employee trust plan, to the extent that the employer, officers, employees, or trustees are engaged in the administration or operation of a program of employee benefits for their own employees or the employees of their subsidiaries or affiliates if the program involves the use of insurance issued by an insurer and the employer, officers, employees, or trustees are not compensated in any manner, directly or indirectly, by the insurer issuing the contracts;

(5) a person who is:

(a) an employee of an insurer or of an organization employed by an insurer, which insurer or organization is engaged in the inspection, rating, or classification of insurance risks or in the supervision of the training of insurance producers; and

(b) not individually engaged in the selling, solicitation, or negotiation of insurance policies and contracts;

(6) an attorney advising a client on general insurance matters, provided the attorney does not sell, solicit, or negotiate insurance;

(7) a salaried full-time employee who counsels or advises the employer or the subsidiaries or affiliates of the employer about the life insurance or annuities if the employee does not sell or solicit insurance or receive a commission or fee;

(8) a person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of this state if the person does not sell, solicit, or negotiate insurance contracts with respect to risks located in this state; or

(9) a person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks with respect to an insured with risks located in more than one state that are insured under the contract if the person is licensed in the state where the insured maintains its principal place of business and the contract insures risks located in that state.

History: En. Sec. 149, Ch. 286, L. 1959; R.C.M. 1947, 40-3305; amd. Sec. 6, Ch. 518, L. 1983; amd. Sec. 19, Ch. 713, L. 1989; amd. Sec. 11, Ch. 427, L. 2003.

Cross-References

Farm mutual insurers — license not required, 33-4-312.
Fraternal benefit societies — special license provisions, 33-7-525.
Reciprocal insurer — attorney-in-fact, 33-17-103.

Part 2
Licensing and Appointment of Insurance Producers and Navigators

Part Cross-References

Hearings on decisions of Commissioner, 33-1-701.
Former criminal offenders — consideration in licensing, 37-1-203.
Licenses — discrimination in issuance prohibited, 49-3-204.

33-17-201. License required of insurance producer — forms — background examinations. (1) A person may not sell, solicit, or negotiate insurance or act as an insurance producer in this state unless licensed as an insurance producer under this chapter.

(2) The commissioner may prescribe by rule and make available the forms required in connection with application for, issuance, continuation, suspension, or termination of a license.

(3) All resident applicants shall undergo prelicensing background examinations. The applicant or insurer shall pay the cost of the background examinations.

History: En. Secs. 147, 151, Ch. 286, L. 1959; R.C.M. 1947, 40-3303(part), 40-3307; amd. Sec. 7, Ch. 518, L. 1983; amd. Sec. 17, Ch. 11, Sp. L. March 1986; amd. Sec. 2, Ch. 409, L. 1987; amd. Sec. 2, Ch. 480, L. 1987; amd. Sec. 12, Ch. 285, L. 1989; amd. Sec. 20, Ch. 713, L. 1989; (6)En. Sec. 4, Ch. 713, L. 1989; amd. Sec. 12, Ch. 427, L. 2003.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-17-202. Repealed. Sec. 68, Ch. 713, L. 1989.

History: En. Sec. 152, Ch. 286, L. 1959; amd. Sec. 7, Ch. 44, L. 1969; amd. Sec. 5, Ch. 423, L. 1971; R.C.M. 1947, 40-3308; amd. Sec. 3, Ch. 409, L. 1987; amd. Sec. 13, Ch. 285, L. 1989; amd. Sec. 6, Ch. 509, L. 1989.

33-17-203. Repealed. Sec. 19, Ch. 409, L. 1987.

History: En. Sec. 153, Ch. 286, L. 1959; amd. Sec. 8, Ch. 44, L. 1969; R.C.M. 1947, 40-3309; amd. Sec. 19, Ch. 198, L. 1979; amd. Sec. 1, Ch. 400, L. 1983.

33-17-204. Repealed. Sec. 68, Ch. 713, L. 1989.

History: En. Sec. 154, Ch. 286, L. 1959; amd. Sec. 9, Ch. 44, L. 1969; R.C.M. 1947, 40-3310; amd. Sec. 1, Ch. 345, L. 1979; amd. Sec. 4, Ch. 409, L. 1987.

33-17-205. Repealed. Sec. 68, Ch. 713, L. 1989.

History: En. Sec. 155, Ch. 286, L. 1959; amd. Sec. 10, Ch. 44, L. 1969; R.C.M. 1947, 40-3311.

33-17-206. Repealed. Sec. 36, Ch. 451, L. 1993.

History: En. Sec. 165, Ch. 286, L. 1959; amd. Sec. 12, Ch. 44, L. 1969; R.C.M. 1947, 40-3321; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 35, Ch. 798, L. 1991.

33-17-207. Repealed. Sec. 4, Ch. 98, L. 1995.

History: En. Sec. 1, Ch. 509, L. 1989; amd. Sec. 1, Ch. 713, L. 1989.

33-17-208. Repealed. Sec. 4, Ch. 98, L. 1995.

History: En. Sec. 2, Ch. 509, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 36, Ch. 16, L. 1991; amd. Sec. 7, Ch. 798, L. 1991.

33-17-209. Repealed. Sec. 4, Ch. 98, L. 1995.

History: En. Sec. 3, Ch. 509, L. 1989; amd. Sec. 1, Ch. 713, L. 1989.

33-17-210. Centralized producer license registry — rules. (1) The commissioner may participate, in whole or in part, with the national association of insurance commissioners, or any affiliates or subsidiaries that the national association of insurance commissioners oversees, in a centralized producer license registry in which insurance producer licenses and appointments may be centrally or simultaneously effected for all states that participate in the registry and that require an insurance producer license.

(2) If the commissioner finds that participation in the centralized producer license registry is in the public interest, the commissioner may adopt by rule any uniform standards and procedures necessary to participate in the registry, including the central collection of all fees for licenses or appointments that are processed through the registry.

History: En. Sec. 1, Ch. 106, L. 2001.

33-17-211. General qualifications — application for license. (1) An individual applying for a license shall apply in a form approved by the commissioner and declare under penalty of refusal, suspension, or revocation of the license that statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall verify that the individual:

(a) is 18 years of age or older;

(b) has not committed an act that is a ground for refusal, suspension, or revocation as set forth in 33-17-1001;

(c) has paid the license fees stated in 33-2-708;

(d) has successfully passed the examinations for each kind of insurance for which the individual has applied within 12 months of application;

(e) is a resident of this state or of another state that grants similar privileges to residents of this state. Licenses issued based upon Montana state residency terminate if the licensee relocates to another state.

(f) is competent, trustworthy, and of good reputation;

(g) has experience or training or otherwise is qualified in the kind or kinds of insurance for which the applicant applies to be licensed and is reasonably familiar with the provisions of this code that govern the applicant's operations as an insurance producer;

(h) if applying for a license as to life or disability insurance, except as permitted by 33-20-1501(1)(c)(ii):

(i) is not a funeral director, undertaker, or mortician operating in this or any other state;

(ii) is not an officer, employee, or representative of a funeral director, undertaker, or mortician operating in this or any other state; or

(iii) does not hold an interest in or benefit from a business of a funeral director, undertaker, or mortician operating in this or any other state; and

(i) has completed a background examination pursuant to 33-17-220.

(2) A resident or nonresident business entity acting as an insurance producer is required to obtain an insurance producer's license. Application must be made in a form approved by the commissioner. To approve the application, the commissioner shall verify that:

(a) the business entity has paid the appropriate fee; and

(b) the business entity has designated an individual licensed insurance producer who is responsible for the business entity's compliance with the insurance laws of this state.

(3) A person acting as an insurance producer shall obtain a license. A person shall apply for a license in a form approved by the commissioner. Before approving the application, the commissioner shall verify that:

(a) the person meets the requirements listed in subsection (1);

(b) the person has paid the licensing fees stated in 33-2-708 for each individual licensed in conjunction with the person's license. A licensed person shall promptly notify the commissioner of each change relating to an individual listed in the license.

(c) the person has designated a licensed officer to be responsible for the person's compliance with the insurance laws and rules of this state;

(d) each member, employee, officer, director, or stockholder of a business entity who is acting as an insurance producer in this state has obtained a license;

(e) (i) with respect to a business entity, the transaction of insurance business is within the purposes stated in the partnership agreement, the articles of incorporation, or other organizational documents; and

(ii) with respect to a corporation, the secretary of state has issued a certificate of existence or registration under 35-14-128 or filed articles of incorporation under 35-14-203.

(4) (a) The commissioner may license as a resident insurance producer an association of licensed Montana insurance producers, whether or not incorporated, formed and existing substantially for purposes other than insurance.

(b) The license must be used solely for the purpose of enabling the association to place, as a resident insurance producer, insurance of the properties, interests, and risks of the state of Montana and of other public agencies, bodies, and institutions and to receive the customary commission for the placement.

(c) The president and secretary of the association shall apply for the license in the name of the association, and the commissioner shall issue the license to the association in the association's name alone.

(d) The fee for the license is the same as that required by 33-2-708(1)(a).

(e) The commissioner may, after a hearing with notice to the association, revoke the license if the commissioner finds that continuation of the license is not in the public interest or that a ground listed in 33-17-1001 exists.

(5) An insurance producer using an assumed business name shall register the name with the commissioner before using the name.

History: En. Sec. 156, Ch. 286, L. 1959; amd. Sec. 19, Ch. 535, L. 1975; R.C.M. 1947, 40-3312; amd. Sec. 20, Ch. 198, L. 1979; amd. Sec. 2, Ch. 345, L. 1979; amd. Sec. 82, Ch. 370, L. 1987; amd. Sec. 5, Ch. 409, L. 1987; amd. Sec. 7, Ch. 509, L. 1989; amd. Sec. 21, Ch. 713, L. 1989; amd. Sec. 210, Ch. 368, L. 1991; amd. Sec. 170, Ch. 411, L. 1991; amd. Sec. 50, Ch. 379, L. 1995; amd. Sec. 8, Ch. 316, L. 1999; amd. Sec. 36, Ch. 7, L. 2001; amd. Sec. 13, Ch. 427, L. 2003; amd. Sec. 13, Ch. 469, L. 2005; amd. Sec. 4, Ch. 399, L. 2007; amd. Sec. 4, Ch. 507, L. 2007; amd. Sec. 9, Ch. 271, L. 2009; amd. Sec. 238, Ch. 271, L. 2019.

33-17-212. Examination required — exceptions — fees. (1) Except as provided in subsection (6), an individual applying for a license is required to pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (5) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) (a) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(b) The commissioner may not charge a fee for an applicant taking an examination pertaining to prepaid legal insurance. However, the commissioner may contract with an outside testing service for administering the examination, and the commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all forms before being rescheduled for another examination.

(4) Except as provided in subsection (6), if the applicant is a business entity, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license must meet the qualifications provided for in this section.

(5) Examination of an applicant for a license must cover only the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;
(b) disability insurance;
(c) property insurance, which for the purposes of this provision includes marine insurance;
(d) casualty insurance;
(e) surety insurance;
(f) surety bail bond insurance;
(g) limited lines credit insurance;
(h) title insurance;
(i) prepaid legal insurance as provided for in 33-1-215.

(6) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or terminated the previous license;

(c) an applicant for a license as a nonresident insurance producer;

(d) a limited lines travel insurance producer and those registered under the limited lines travel insurance producer's license pursuant to 33-17-1402;

(e) an association applying for a license under 33-17-211; or

(f) a casualty insurance producer for the purposes of a separate exam for prepaid legal insurance if the casualty insurance producer sells prepaid legal insurance as of April 26, 2013, and continues to maintain a license in good standing as a casualty insurance producer.

(7) (a) Subject to the provisions of subsection (7)(b), an individual who applies for a nonresident insurance producer license in this state and who was previously licensed for the same lines of authority in another state may not be required to complete any prelicensing education or examination.

(b) The exemption in subsection (7)(a) is available only if the individual is currently licensed in the other state or the individual's application is received within 90 days of the cancellation of the individual's previous license and if the other state issues a certification that, at the time of the cancellation, the individual was in good standing in that state or the state's database records, maintained by the national association of insurance commissioners or any of the association's affiliates or subsidiaries that the association oversees, indicate that the insurance producer is or was licensed in good standing for the lines of authority requested.

History: En. Sec. 157, Ch. 286, L. 1959; amd. Sec. 11, Ch. 44, L. 1969; R.C.M. 1947, 40-3313; amd. Sec. 3, Ch. 345, L. 1979; amd. Sec. 1, Ch. 211, L. 1981; amd. Sec. 18, Ch. 519, L. 1985; amd. Sec. 6, Ch. 409, L. 1987; amd. Sec. 1, Ch. 480, L. 1987; amd. Sec. 22, Ch. 713, L. 1989; amd. Sec. 25, Ch. 531, L. 1997; amd. Sec. 9, Ch. 316, L. 1999; amd. Sec. 31, Ch. 472, L. 1999; amd. Sec. 4, Ch. 106, L. 2001; amd. Sec. 14, Ch. 427, L. 2003; amd. Sec. 10, Ch. 271, L. 2009; amd. Sec. 5, Ch. 313, L. 2009; amd. Sec. 1, Ch. 324, L. 2013; amd. Sec. 5, Ch. 359, L. 2013; amd. Sec. 4, Ch. 592, L. 2023.

Cross-References

Types of insurance — definitions, 33-1-205 through 33-1-212.
Licensing reciprocity, 33-17-401.
Montana Title Insurance Act, Title 33, ch. 25.

33-17-213. Conduct of examinations. (1) The commissioner shall make any examination required under 33-17-212 available to applicants with reasonable frequency and at places in this state reasonably accessible to the applicants.

(2) The commissioner shall assure that the examinations are conducted in a fair and impartial manner and without unfair discrimination as between individuals examined.

(3) The commissioner may require a reasonable waiting period before reexamination of an applicant who has failed to pass a previous examination covering the same kind or kinds of insurance.

(4) The examination of a title insurance producer, as defined in 33-25-105, must include but is not limited to questions pertaining to the search and examination of title to real property, insurance principles relating to title insurance, and the fiduciary duties and procedures of escrows, settlements, and closings of real estate transactions.

History: En. Sec. 158, Ch. 286, L. 1959; amd. Sec. 1, Ch. 156, L. 1969; R.C.M. 1947, 40-3314; amd. Sec. 21, Ch. 198, L. 1979; amd. Sec. 19, Ch. 519, L. 1985; amd. Sec. 7, Ch. 409, L. 1987; amd. Sec. 23, Ch. 713, L. 1989.

33-17-214. Issuance of license — insurance producer lines of authority — license data — lapse of license — change of address. (1) A person who has met the requirements of 33-17-211 and 33-17-212 must be issued a license unless that person has been denied a license pursuant to 33-17-1001.

(2) An insurance producer may receive a license qualifying the insurance producer in one or more of the following lines of authority:

(a) life insurance coverage on human lives, including benefits of endowment and annuities, and the coverage may include:

(i) funeral insurance as defined in 33-20-1501;

(ii) benefits in the event of death or dismemberment by accident; and

(iii) benefits for disability income;

(b) accident and health or sickness insurance coverage providing for sickness, bodily injury, or accidental death, and the coverage may provide benefits for disability income;

(c) property insurance coverage for the direct or consequential loss or damage to property of every kind;

(d) casualty insurance coverage against legal liability, including liability for death, injury, or disability or damage to real or personal property;

(e) variable life and variable annuity products insurance coverage provided under variable life insurance contracts and variable annuities;

(f) personal lines of property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(g) limited line credit insurance; or

(h) any other line of insurance permitted under Title 33.

(3) The license must state the name and primary business address of the licensee, personal identification number, date of issuance, general conditions relative to expiration or termination, kind of insurance covered, and other information that the commissioner considers necessary.

(4) The license of a business entity must also state the name of each individual authorized to exercise the license powers.

(5) Each license remains in effect unless it is suspended, revoked, or terminated or the license lapses.

(6) (a) A person shall inform the commissioner in writing within 30 days of:

(i) a change of address or a change of business e-mail address;

(ii) the final disposition resulting in disciplinary action taken against or a conviction of the insurance producer in any state or federal jurisdiction or by another governmental agency in this state of:

(A) any administrative action related to transacting insurance;

(B) any action taken against any type of securities license; and

(C) any criminal action, excluding traffic violations.

(b) (i) As used in this subsection (6), "final disposition" includes but is not limited to a settlement agreement, consent order, plea agreement, sentence and judgment, or order.

(ii) The term does not include an action that is dismissed or that results in an acquittal, for which a report is not necessary.

History: En. Sec. 159, Ch. 286, L. 1959; R.C.M. 1947, 40-3315; amd. Sec. 4, Ch. 345, L. 1979; amd. Sec. 24, Ch. 713, L. 1989; amd. Sec. 10, Ch. 316, L. 1999; amd. Sec. 5, Ch. 106, L. 2001; amd. Sec. 15, Ch. 427, L. 2003; amd. Sec. 5, Ch. 399, L. 2007; amd. Sec. 5, Ch. 507, L. 2007; amd. Sec. 11, Ch. 271, L. 2009; amd. Sec. 6, Ch. 313, L. 2009; amd. Sec. 12, Ch. 169, L. 2013.

33-17-215. Repealed. Sec. 14, Ch. 345, L. 1979.

History: En. Sec. 160, Ch. 286, L. 1959; R.C.M. 1947, 40-3316.

33-17-216. Temporary insurance producer license. (1) The commissioner may issue a temporary license to or with respect to an individual qualified for the temporary license only as to age, residence, and trustworthiness and without requiring the individual to take an examination, in the following cases:

(a) to the surviving spouse or next of kin or to the administrator or executor, or the employee of the administrator or executor, of a licensed insurance producer upon the insurance producer's death;

(b) to the spouse, next of kin, employee, or legal guardian of a licensed insurance producer disabled by injury or physical or mental illness;

(c) to an employee of a partnership, or officer or employee of a corporation, licensed as an insurance producer, upon the death or disability of an individual designated in the license to exercise the powers of an insurance producer;

(d) to the designee of a licensed insurance producer entering upon active service in the armed forces of the United States of America;

(e) in any other circumstance in which the commissioner finds that the public interest will best be served by issuing a temporary license.

(2) The temporary license must be issued upon application filed with the commissioner in the form and containing the information as the commissioner may reasonably require.

(3) The temporary license must be for a period of not over 90 days, subject to extension at the commissioner's discretion for an additional period of not more than 90 days, except that a temporary license issued pursuant to subsection (1)(a) may be continued until the executor or administrator disposes of the insurance business, but not to exceed a period of 15 months. A temporary license issued to the next of kin under subsection (1)(a) may not be extended for an additional term after the appointment and qualification of the administrator or executor.

History: En. Sec. 163, Ch. 286, L. 1959; R.C.M. 1947, 40-3319; amd. Sec. 27, Ch. 198, L. 1979; amd. Sec. 5, Ch. 345, L. 1979; amd. Sec. 25, Ch. 713, L. 1989; amd. Sec. 11, Ch. 316, L. 1999.

33-17-217. Limitations and rights under temporary license. (1) The commissioner may not issue more than one temporary license, to or with respect to the same individual to be licensed, within any 12-month period.

(2) The temporary license may cover the same kinds of insurance for which the insurance producer being replaced was licensed.

(3) As to a temporary insurance producer's license issued on account of the death or disability of an insurance producer, the licensee may represent all of the insurers last represented by the deceased or disabled insurance producer, but the licensee may not be licensed for an additional kind of insurance under the temporary license.

(4) A temporary licensee has the same license powers and duties as under a permanent license.

History: En. Sec. 164, Ch. 286, L. 1959; R.C.M. 1947, 40-3320; amd. Sec. 26, Ch. 713, L. 1989.

33-17-218. Repealed. Sec. 68, Ch. 713, L. 1989.

History: En. Sec. 172, Ch. 286, L. 1959; amd. Sec. 13, Ch. 44, L. 1969; R.C.M. 1947, 40-3328; amd. Sec. 2, Ch. 344, L. 1979; amd. Sec. 6, Ch. 345, L. 1979.

33-17-219. Inactive status — insurance producers serving in armed forces. (1) The commissioner may place an insurance producer on inactive status if the insurance producer enters active service in the armed forces of the United States.

(2) An insurance producer may not transact the business of insurance while on inactive status.

(3) The commissioner shall waive the continuing education requirements in 33-17-1205 and the fee in 33-2-708 while an insurance producer is on inactive status.

(4) In order to be placed on inactive status, an insurance producer shall notify the commissioner when called to active service.

(5) In order to be taken off inactive status, an insurance producer shall notify the commissioner when discharged from active service.

History: En. Sec. 1, Ch. 427, L. 2003.

33-17-220. Licensing background examination — action by commissioner. (1) (a) Each applicant for a producer's license or navigator certification shall obtain a complete background examination. The applicant or insurer shall pay the cost of the background examination. The background examination report must provide information to confirm:

(i) the applicant's:

(A) identity;

(B) current address;

(C) professional license certification; and

(D) military service; and

(ii) (A) existing or ongoing criminal investigations and court records relating to the applicant; and

(B) regulatory agencies' disciplinary actions concerning the applicant.

(b) The background examination is confidential and may not be held as part of the licensee's or navigator's public file.

(c) (i) The commissioner may, when initially making a decision regarding an applicant's navigator certification, consider the findings obtained from the background examination, including an existing or ongoing criminal investigation or any disciplinary action taken by a regulatory agency against the applicant that relates to the applicant's suitability for navigator certification.

(ii) The commissioner may not issue navigator certification to an applicant if the background examination discloses an act by the applicant that, under 33-17-1001, would allow the commissioner to suspend, revoke, refuse to renew, or refuse to issue an insurance producer's license.

(iii) If the commissioner initially approves an applicant's navigator certification while the applicant is the subject of a criminal investigation or is potentially subject to disciplinary action and the applicant is subsequently found to have committed an act that, under 33-17-1001, would allow the commissioner to suspend, revoke, refuse to renew, or refuse to issue an insurance producer's license, the commissioner may suspend or, pursuant to subsection (1)(c)(iv), shall revoke the navigator certification.

(iv) The commissioner shall immediately revoke a navigator's certification if the commissioner discovers that the navigator has committed an act that, under 33-17-1001, would allow the commissioner to suspend, revoke, refuse to renew, or refuse to issue an insurance producer's license.

(2) For the purpose of obtaining a state and a federal criminal records check pursuant to subsection (1), the commissioner may require a person applying for a license or navigator certification to submit a full set of fingerprints to the commissioner. The commissioner shall submit the fingerprints to the Montana department of justice. The Montana department of justice may exchange this fingerprint data with the federal bureau of investigation.

(3) The commissioner may require fingerprints to be collected and remitted in an electronic format to facilitate periodic resubmission of fingerprints.

(4) The commissioner may contract for the collection, transmission, and retention of fingerprints and may agree to a reasonable fee charged by a contractor for these services. If the commissioner contracts for services, the fee for collecting, transmitting, and retaining of fingerprints must be paid directly to the contractor by the applicant or insurer.

(5) The commissioner is authorized to receive criminal history record information in lieu of the Montana department of justice relating to fingerprints submitted to the federal bureau of investigation.

(6) The commissioner may adopt rules to further implement this section, including but not limited to rules on the length of time that a background examination is valid and rules for the electronic filing of fingerprints.

History: En. Sec. 2, Ch. 427, L. 2003; amd. Sec. 14, Ch. 469, L. 2005; amd. Sec. 7, Ch. 245, L. 2013; amd. Sec. 1, Ch. 346, L. 2015.

33-17-221. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 166, Ch. 286, L. 1959; R.C.M. 1947, 40-3322; amd. Sec. 27, Ch. 713, L. 1989; amd. Sec. 12, Ch. 316, L. 1999.

33-17-222 through 33-17-230 reserved.

33-17-231. Appointment of insurance producers — continuation and termination. (1) Each insurer appointing an insurance producer in this state shall file with the commissioner the appointment, specifying the kinds of insurance to be transacted by the insurance producer for the insurer. The appointment may be electronically filed. The commissioner may adopt rules to implement electronic filing.

(2) Each appointment remains in effect until the insurance producer's license is revoked or otherwise terminated unless written notice of earlier termination of the appointment is filed with the commissioner by the insurer or the insurance producer. The written notice may be electronically filed. The commissioner may adopt rules to implement electronic filing. Termination of the insurer's authority in Montana also terminates the appointment.

(3) Subject to the insurance producer's contract rights, an insurer may terminate an insurance producer's appointment at any time. The insurer shall promptly give written notice of the termination to the commissioner and to the insurance producer. The commissioner may require reasonable proof that the insurer has given notice to the insurance producer.

(4) As part of the notice of termination given the commissioner, the insurer shall file with the commissioner a statement of the facts relative to the termination and the cause of termination. Any information or statement contained in the notice of termination is not admissible as evidence in any action or proceeding against the insurer or any representative of the insurer by or on behalf of any person affected by the termination.

(5) (a) An insurer that sells a qualified health plan in an exchange operating in this state shall appoint any producer who is certified by the commissioner pursuant to 33-17-243 and follows the appointment application process required by that insurer.

(b) To maintain the appointment, the producer shall maintain the producer's certification and license in good standing.

(6) An appointment by affiliation terminates automatically on termination of the affiliation.

History: En. Sec. 161, Ch. 286, L. 1959; R.C.M. 1947, 40-3317; amd. Sec. 3, Ch. 344, L. 1979; amd. Sec. 7, Ch. 345, L. 1979; amd. Sec. 8, Ch. 409, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 20, Ch. 451, L. 1993; amd. Sec. 2, Ch. 6, Sp. L. November 1993; amd. Sec. 13, Ch. 316, L. 1999; amd. Sec. 12, Ch. 271, L. 2009; amd. Sec. 8, Ch. 245, L. 2013; amd. Sec. 2, Ch. 38, L. 2017; amd. Sec. 1, Ch. 110, L. 2019.

33-17-232. Rights of insurance producer following termination of appointment. (1) Following termination of an agency appointment for property, casualty, title, or surety insurance and subject to the terms of an agreement between the insurance producer and the insurer, the insurance producer may continue to service and receive from the insurer commissions or other compensation relative to business written by the insurance producer for the insurer during the existence of the appointment.

(2) This section does not apply to:

(a) insurance producers of direct writing insurers; or

(b) insurance producers or insurers between whom the relationship of employer and employee exists.

History: **En. Sec. 162, Ch. 286, L. 1959; R.C.M. 1947, 40-3318; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 6, Ch. 399, L. 2007.**

33-17-233 through 33-17-235 reserved.

33-17-236. Appointments of insurance producers by insurers. (1) An insurance producer may not claim to be a representative of or an authorized or appointed insurance producer of or use another term implying a contractual relationship with a particular insurer unless the insurance producer is an appointed insurance producer of that insurer pursuant to this section. This does not prevent an insurance producer from obtaining and presenting a quotation from an insurer with whom the producer is not appointed. If the insurer consents, the insurer may bind coverage on a risk in accordance with 33-15-411 prior to the execution of an agency contract and policy issuance.

(2) The insurer shall, not later than 15 days from the date on which the agency contract is executed with an insurance producer, file with the commissioner a written notice of appointment on a form prescribed by the commissioner. The notice may be electronically filed pursuant to rules adopted by the commissioner.

(3) Upon receipt of the notice of appointment, the commissioner shall verify that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the commissioner shall notify the insurer of the determination.

(4) (a) An appointment is effective on the earlier of the date of the executed agency contract or the date on which the insurer files the notice of appointment with the commissioner, unless the appointment is disapproved by the commissioner.

(b) A disapproved appointment is void on the date the department provides notification to the insurer.

(c) An appointment of which notice is not filed within 15 days of execution of the agency contract is not effective until the date that the insurer files the notice of appointment with the commissioner.

(5) An appointment is perpetual until canceled by the insurer.

History: **En. Sec. 5, Ch. 713, L. 1989; amd. Sec. 3, Ch. 6, Sp. L. November 1993; amd. Sec. 32, Ch. 472, L. 1999; amd. Sec. 3, Ch. 38, L. 2017; amd. Sec. 2, Ch. 110, L. 2019.**

33-17-237. Notification of violation or appointment termination. (1) On the termination of an appointed insurance producer by an insurer, the insurer shall notify the commissioner within 30 days in the manner prescribed by the commissioner, which may include electronic filing.

(2) If the reason for the termination is any of the causes listed in 33-17-1001 or 33-25-301, the insurer shall immediately notify the commissioner of the reason.

(3) Whenever an insurance company or an employee or representative of the company has reasonable cause to believe that a person has violated 33-17-1001 or 33-25-301, it is the duty of that entity, upon acquiring the knowledge, to notify the commissioner and provide the commissioner with a complete statement of all relevant facts and circumstances.

(4) The insurer, employee, or representative shall, on request of the commissioner, provide information, documents and records, or other data pertaining to the alleged violation or termination that may be used by the commissioner in any action taken pursuant to Title 33, chapter 17, part 10.

(5) Any information, documents, records, or other data provided pursuant to this section is privileged, and there is no liability on the part of nor may a cause of action of any nature arise against the commissioner, the insurance company, or an authorized representative of either so long as the privileged information is furnished in good faith.

History: **En. Sec. 6, Ch. 713, L. 1989; amd. Sec. 21, Ch. 451, L. 1993; amd. Sec. 4, Ch. 6, Sp. L. November 1993; amd. Sec. 13, Ch. 8, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 13, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-17-238. Appointment by affiliation. (1) Unless prohibited by the insurer, a business entity insurance producer may satisfy the appointment requirements of 33-17-236(1) by affiliating with a business entity insurance producer that has been appointed directly by the insurer.

(2) A business entity insurance producer obtaining an appointment by affiliation under subsection (1) shall maintain a copy of each written affiliation agreement for 3 years following termination of the affiliation and make copies of the agreement available to the commissioner upon request.

(3) An appointment by affiliation under subsection (1) is effective on the date the business entity insurance producer enters into an affiliation agreement.

(4) A business entity insurance producer appointed by affiliation under this section is authorized to transact the kinds of insurance for which the business entity insurance producer directly appointed by the insurer is also authorized, except:

(a) a business entity insurance producer appointed by affiliation may not transact kinds of insurance for which the insurance producer is not otherwise authorized; and

(b) the insurer may specify in writing those kinds of insurance the business entity insurance producer may transact under the appointment.

History: En. Sec. 1, Ch. 38, L. 2017; amd. Sec. 3, Ch. 110, L. 2019.

33-17-239 and 33-17-240 reserved.

33-17-241. Navigator certification — duties — prohibitions. (1) An individual or an individual performing navigator duties on behalf of an organization serving as a navigator may not act in the capacity of a navigator unless the individual has met all of the following requirements, as applicable:

(a) is at least 18 years of age;

(b) has completed and submitted the application form provided for in 33-17-242 and has declared, under penalty of refusal, suspension, or revocation of the navigator's certification, that the statements made in the form are true, correct, and complete to the best of the applicant's knowledge and belief;

(c) has completed a background examination as described in 33-17-220;

(d) has documentation of successful completion of the centers for medicare and medicaid services navigator certification training requirements or navigator recertification training requirements, as applicable; and

(e) has paid all fees required by 33-2-708.

(2) A navigator's duties may include any of the following:

(a) conducting public education activities to raise awareness of the availability of qualified health plans;

(b) distributing fair and impartial general information concerning how to enroll in any qualified health plan offered within the exchange and the availability of the premium tax credits under 26 U.S.C. 36B and the cost-sharing reductions provided under 42 U.S.C. 18071;

(c) assisting consumers in understanding how to enroll in a qualified health plan through an exchange or appropriate public programs offering health care coverage, without suggesting that the consumer purchase any particular plan; and

(d) referring consumers to the commissioner's office for assistance with complaints, appeals, or grievances or for general information about health insurance.

(3) A navigator may not do any of the following unless the navigator is otherwise licensed or authorized to do so under this chapter:

(a) sell, solicit, or negotiate health insurance;

(b) recommend, endorse, or offer opinions about the benefits, terms, or features of a particular health benefit plan or offer an opinion about which health benefit plan is better or worse for a particular individual or employer;

(c) provide any information or services related to a health benefit plan or another product not offered in the exchange;

(d) engage in any unfair method of competition or any fraudulent, deceptive, or dishonest act or practice; or

(e) enroll an individual or an employee in a qualified health plan offered through an exchange.

History: En. Sec. 2, Ch. 245, L. 2013; amd. Sec. 2, Ch. 346, L. 2015; amd. Sec. 1, Ch. 486, L. 2023.

33-17-242. Commissioner's duties — navigator certification — training for certified application counselors and others. (1) The commissioner shall:

(a) develop a navigator certification application form that requires an applicant to disclose potential conflicts of interest and any other information the commissioner considers relevant; and

(b) certify an applicant meeting the requirements of 33-17-241(1).

(2) The commissioner may suspend, revoke, or refuse to issue or renew the navigator certification of a person that has committed an act for which the grounds for denial, suspension, or revocation are described in 33-17-1001 regarding an insurance producer's license.

(3) The commissioner may not certify as a navigator an individual, organization, or business entity that is receiving financial compensation, including monetary or in-kind compensation, gifts, or grants, from an insurer. A navigator certification must be revoked if the navigator receives financial compensation as described in this subsection from an insurer.

(4) The commissioner may prescribe training for an application counselor provided for in federal rule and other persons who while not part of the navigator program assist those who sign up for an exchange. The commissioner may require completion of the training before certification by the exchange. The training must be designed for those who assist applicants seeking to enroll in coverage through the exchange.

History: En. Sec. 3, Ch. 245, L. 2013; amd. Sec. 2, Ch. 486, L. 2023.

33-17-243. Producer exchange training — certification for exchange sales. A producer may not sell, solicit, or negotiate insurance through an exchange on or after October 1, 2013, without first completing the producer exchange training and certification program as prescribed and approved by the commissioner.

History: En. Sec. 4, Ch. 245, L. 2013; amd. Sec. 18, Ch. 151, L. 2017; amd. Sec. 14, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 14, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-17-244. Lists of certified producers and navigators. (1) An exchange operating in this state shall maintain a current list of both of the following:

(a) licensed insurance producers that have met all of the producer exchange training and certification program requirements necessary to sell insurance through an exchange, as provided in 33-17-243; and

(b) individuals or entities that have met all the requirements to be certified by the commissioner as navigators.

(2) Upon request, the commissioner shall make available a list of insurance producers that are certified to sell a health benefit plan through an exchange and are operating near the requester's address. The commissioner shall also make available a list of certified navigators.

History: En. Sec. 5, Ch. 245, L. 2013.

Part 3
Adjusters

Part Cross-References

Hearings on decisions of Commissioner, 33-1-701.
Former criminal offenders — consideration in licensing, 37-1-203.
Private investigators — nonapplicability of provisions, 37-60-105.
Licenses — discrimination in issuance prohibited, 49-3-204.

33-17-301. Adjuster license — qualifications — catastrophe adjustments — education and examination exemption. (1) A person may not act as or purport to be an adjuster in this state unless the person holds an adjuster license. A person shall apply to the commissioner for an adjuster license in a form approved by the commissioner. The commissioner shall issue the license to persons qualified to be licensed under this section.

(2) To be licensed as an individual adjuster, the applicant:

(a) must be an individual 18 years of age or older;

(b) (i) must be a resident of Montana or a resident of another state that permits residents of Montana regularly to act as adjusters in the other state; or

(ii) if not a resident of this state, shall designate a home state in which the adjuster does not maintain a place of business or residence if:

(A) the adjuster's principal state of business or residence does not offer adjuster licensure; and

(B) the adjuster qualifies for the license as if the adjuster were a resident of the designated home state;

(c) except as provided in subsection (4), shall pass an adjuster licensing examination as prescribed by the commissioner and pay the fee pursuant to 33-2-708;

(d) must be trustworthy and of good character and reputation;

(e) shall submit to a licensing background examination that meets the requirements provided in 33-17-220; and

(f) shall maintain in this state an office accessible to the public and shall keep in the office for not less than 5 years the usual and customary records pertaining to transactions under the license. This provision does not prohibit maintenance of the office in the home of the licensee.

(3) A business entity, whether or not organized under the laws of this state, may be licensed under this section if each individual who is to exercise the license powers is separately licensed or is named in the business entity license and is qualified for an individual license under this section.

(4) (a) Subject to the provisions of subsection (4)(b), an individual who applies for a nonresident license under this section in this state and who was previously licensed in another state may not be required to complete any prelicensing education or examination requirements.

(b) The exemption in subsection (4)(a) is available only if the individual is currently licensed in the other state or the individual's application is received within 90 days of the cancellation of the individual's previous license and the other state issues a certification or the state's database records indicate that, at the time of the cancellation, the individual was in good standing in that state.

(5) An adjuster license or qualifications are not required for an adjuster who is sent into this state by and on behalf of an insurer or adjusting business entity for the purpose of investigating or making adjustments of a particular loss under an insurance policy or for the adjustment of a series of losses resulting from a catastrophe common to all losses.

(6) A license issued under this section continues in force until lapsed, suspended, revoked, or terminated. The licensee shall renew the license by the biennial renewal date and pay the appropriate fee or the license will lapse. The biennial fee is established pursuant to 33-2-708.

(7) For purposes of this section, "adjuster" includes adjusters and public adjusters as defined in 33-17-102.

History: En. Sec. 171, Ch. 286, L. 1959; amd. Sec. 6, Ch. 423, L. 1971; R.C.M. 1947, 40-3327; amd. Sec. 28, Ch. 713, L. 1989; amd. Sec. 26, Ch. 531, L. 1997; amd. Sec. 14, Ch. 316, L. 1999; amd. Sec. 16, Ch. 427, L. 2003; amd. Sec. 15, Ch. 469, L. 2005; amd. Sec. 13, Ch. 271, L. 2009; amd. Sec. 13, Ch. 169, L. 2013; amd. Sec. 10, Ch. 406, L. 2013; amd. Sec. 4, Ch. 139, L. 2015; amd. Sec. 19, Ch. 151, L. 2017.

33-17-302. Public adjuster contracts — financial disclosure. (1) A person licensed as a public adjuster may not act as a public adjuster unless the person has a written contract with the insured. Written contracts must be filed with the commissioner and must contain all of the following:

(a) legible full name of the adjuster signing the contract as specified in records held by the commissioner;

(b) business address and telephone number of the public adjuster;

(c) license number of the public adjuster;

(d) title specifying "public adjuster contract";

(e) insured's full name, street address, insurer name, and policy number, if known or upon notification;

(f) description of the loss and its location, if applicable;

(g) description of services to be provided to the insured;

(h) signatures of the public adjuster and the insured;

(i) date the contract was signed by the public adjuster and the date the contract was signed by the insured;

(j) attestation language stating that the public adjuster is fully bonded pursuant to state law; and

(k) full salary, fee, commission, compensation, or other consideration the public adjuster is to receive for services.

(2) A public adjuster contract may not contain any contract term that:

(a) allows the public adjuster's percentage fee to be collected when money is due from an insurer but not paid or that allows a public adjuster to collect the entire fee from the first payment issued by the insurer rather than as a percentage of each payment issued by an insurer;

(b) requires the insured to authorize an insurer to issue payment only in the name of the public adjuster;

(c) imposes collection costs or late fees; or

(d) precludes an insured from pursuing civil remedies.

(3) If the insurer either pays or commits in writing to pay the insured policy limits of the insurance policy within 72 hours after the date the loss is reported, the public adjuster may not:

(a) receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim; or

(b) inform the insured that loss recovery amount will likely not be increased by the insurer.

(4) A public adjuster shall provide the insured with a written disclosure document concerning any direct or indirect financial interest that the public adjuster has with any other party involved in any aspect of the claim or services rendered by the public adjuster. The document must include a disclosure of any ownership interest in an entity that performs work in conjunction with the claim on which the public adjuster is engaged, including but not limited to any:

(a) construction firm;

(b) salvage firm;

(c) building appraisal firm;

(d) motor vehicle repair shop; or

(e) other entity that provides estimates for work or that performs any work.

History: **En. Sec. 5, Ch. 139, L. 2015.**

33-17-303. Public adjuster standards of conduct. A public adjuster:

(1) is obligated to serve with objectivity and loyalty to the interest of the insured alone;

(2) may not solicit or attempt to solicit an insured during the progress of a loss-producing occurrence, as defined in the insured's insurance contract;

(3) may not permit an unlicensed employee or representative of the public adjuster to conduct business for which a license is required;

(4) may not acquire any interest in the salvage of property subject to the contract with the insured without written permission from the insured;

(5) shall abstain from referring or directing the insured to any person with whom the public adjuster has a financial interest unless disclosed to the insured pursuant to 33-17-302(4).

History: **En. Sec. 6, Ch. 139, L. 2015.**

Part 4
Nonresident Licensees

Part Cross-References

Residence — rules for determining, 1-1-215.

Licenses — discrimination in issuance prohibited, 49-3-204.

33-17-401. Nonresident insurance producer — license. (1) A nonresident person, unless denied licensure pursuant to 33-17-1001, must be granted a license if:

(a) the person is currently licensed as a resident and is in good standing in the person's home state;

(b) the person has submitted the proper request for licensure and has paid the fees required by 33-2-708;

(c) the person has submitted or transmitted to the commissioner the application for licensure that the person submitted to the person's home state or a completed application in a form approved by the commissioner; and

(d) the person's home state awards nonresident insurance producer licenses to residents of this state on the same basis.

(2) A person licensed as a surplus lines producer in that person's home state must receive a nonresident surplus lines producer license upon meeting the requirements of subsection (1). Except for subsection (1), this section does not amend or supersede any provision of the surplus lines insurance law established in Title 33, chapter 2, part 3.

(3) A person licensed as a limited line credit insurance producer or other type of limited lines producer in that person's home state must receive a nonresident limited lines producer license upon meeting the requirements of subsection (1), granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited lines insurance is any authority granted by a nonresident's home state that restricts the authority of the licensee to less than the total authority prescribed in the associated major lines pursuant to 33-17-214(2)(a) through (2)(e).

(4) If a nonresident insurance producer's state of residence suspends, revokes, or terminates the insurance producer's insurance license in that state, the insurance producer's Montana nonresident license automatically terminates. The nonresident insurance producer shall notify the commissioner that the insurance producer's state of residence has suspended, revoked, or terminated the insurance producer's insurance license in that state.

History: **En. Sec. 1, Ch. 44, L. 1969; R.C.M. 1947, 40-3333; amd. Sec. 8, Ch. 345, L. 1979; amd. Sec. 9, Ch. 409, L. 1987; amd. Sec. 29, Ch. 713, L. 1989; amd. Sec. 6, Ch. 106, L. 2001; amd. Sec. 16, Ch. 469, L. 2005.**

33-17-402. Repealed. Sec. 68, Ch. 713, L. 1989.

History: **En. Sec. 2, Ch. 44, L. 1969; R.C.M. 1947, 40-3334.**

33-17-403. Repealed. Sec. 68, Ch. 713, L. 1989.

History: **En. Sec. 3, Ch. 44, L. 1969; R.C.M. 1947, 40-3335.**

33-17-404. Repealed. Sec. 73, Ch. 227, L. 2001.

History: **En. Sec. 4, Ch. 44, L. 1969; R.C.M. 1947, 40-3336; amd. Sec. 9, Ch. 345, L. 1979; amd. Sec. 1, Ch. 395, L. 1983; amd. Sec. 30, Ch. 713, L. 1989.**

33-17-405. Repealed. Sec. 54, Ch. 157, L. 2023.

History: **En. Sec. 5, Ch. 44, L. 1969; R.C.M. 1947, 40-3337; amd. Sec. 31, Ch. 713, L. 1989; amd. Sec. 51, Ch. 379, L. 1995.**

33-17-406. Nonresident insurance producer subject to insurance code. A nonresident insurance producer is subject to the provisions of the Montana Insurance Code as though a resident of this state, unless otherwise provided.

History: **En. Sec. 6, Ch. 44, L. 1969; R.C.M. 1947, 40-3338; amd. Sec. 32, Ch. 713, L. 1989.**

33-17-407. Nonresident insurance producer to pay taxes — annual report required. (1) A nonresident insurance producer is subject to personal income, business income, or corporate income taxes for all income earned on insurance policies issued to cover subjects or risks residing, located, or to be performed in Montana and written within the boundaries of this state.

(2) A nonresident insurance producer shall file annually a Montana income tax return as required in Title 15.

History: **En. Sec. 3, Ch. 395, L. 1983; amd. Sec. 33, Ch. 713, L. 1989; amd. Sec. 35, Ch. 268, L. 2013.**

Cross-References

Premium tax imposed on policy issued through nonresident licensee, 33-2-710.

33-17-408. Reciprocity — nonresident insurance producer licensing and continuing education. (1) The commissioner shall waive any requirements, except for the requirements of 33-17-401, for a nonresident applicant for an insurance producer's license who has a valid license from the applicant's home state if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(2) A nonresident insurance producer's satisfaction of the insurance producer's home state's continuing education requirements for licensed insurance producers constitutes satisfaction of this state's continuing education requirements if the nonresident insurance producer's home state recognizes the satisfactions of its continuing education requirements imposed upon insurance producers from this state on the same basis.

History: **En. Sec. 8, Ch. 106, L. 2001.**

33-17-409. Status of nonresident insurance producers — biennial renewal of license — payment of fees. A nonresident insurance producer's license continues in force until lapsed, suspended, revoked, or terminated. The license lapses if the licensee fails to remit a biennial renewal fee.

History: **En. Sec. 5, Ch. 427, L. 2003.**

33-17-410. Service of process. Service of process against a nonresident person must be made pursuant to 35-7-113 or in any other manner permitted by law.

History: **En. Sec. 17, Ch. 157, L. 2023.**

33-17-411. Penalty. A nonresident insurance producer who violates a condition of the producer's Montana license or a provision of this part is subject to a fine by the commissioner of up to $50,000 for each violation and may, at the discretion of the commissioner, have the Montana nonresident license revoked or suspended for a period of up to 5 years.

History: **En. Sec. 5, Ch. 395, L. 1983; amd. Sec. 34, Ch. 713, L. 1989; amd. Sec. 1204, Ch. 56, L. 2009.**

Part 5
Consultants

Part Cross-References

Hearings on decisions of Commissioner, 33-1-313.
Former criminal offenders — consideration in licensing, 37-1-203.
Licenses — discrimination in issuance prohibited, 49-3-204.

33-17-501. Short title. This part may be cited as "The Montana Insurance Consultant Licensure Act".

History: **En. 40-3339 by Sec. 1, Ch. 144, L. 1975; R.C.M. 1947, 40-3339.**

33-17-502. Prohibition on representation as consultant — receiving fee. (1) A person not licensed as an insurance consultant in this state who identifies or represents to the public that the person is an insurance consultant without having been licensed as an insurance consultant under this part or a person who uses any other designation or title that is likely to mislead the public and represents to the public that the person has particular insurance qualifications other than those for which the person may be otherwise licensed or otherwise qualified may be fined pursuant to 33-1-317.

(2) A person not licensed as an insurance consultant with respect to the relevant kinds of insurance who receives a fee for examining, appraising, reviewing, or evaluating any insurance policy, annuity or pension contract, plan, or program or who makes recommendations or gives advice with regard to any insurance policy, annuity or pension contract, plan, or program without first having been licensed by the commissioner as an insurance consultant may be fined pursuant to 33-1-317.

(3) This part does not apply to:

(a) licensed attorneys at law in this state acting in their professional capacity; or

(b) an actuary or a certified public accountant who provides information, recommendations, advice, or services in a professional capacity if neither the actuary nor the certified public accountant or the actuary's or certified public accountant's employer receives any compensation directly or indirectly on account of any insurance, bond, annuity or pension contract that results in whole or part from that information, recommendation, advice, or services.

History: **En. 40-3340, 40-3348 by Secs. 2, 10, Ch. 144, L. 1975; R.C.M. 1947, 40-3340, 40-3348; amd. Sec. 2, Ch. 86, L. 1979; amd. Sec. 40, Ch. 613, L. 1989; amd. Sec. 35, Ch. 713, L. 1989; amd. Sec. 44, Ch. 227, L. 2001; amd. Sec. 17, Ch. 427, L. 2003.**

33-17-503. Application — residency — fee — expiration. (1) Before a consultant license is issued or renewed, the prospective licensee shall:

(a) properly file with the office of the commissioner a written application in a form approved by the commissioner; and

(b) pay a fee pursuant to 33-2-708, which the commissioner shall forward to the state treasurer to be deposited in the state special revenue fund to the credit of the state auditor's office.

(2) To be licensed as a consultant, the prospective licensee:

(a) must be an individual 18 years of age or older; and

(b) (i) must be a resident of Montana or a resident of another state that permits residents of Montana regularly to act as consultants in the other state; or

(ii) if not a resident of this state, shall designate a home state in which the consultant does not maintain a place of business or residence if:

(A) the consultant's principal state of business or residence does not offer consultant licensure; and

(B) the consultant qualifies for the license as if the consultant were a resident of the designated home state.

(3) A consultant license continues in force until lapsed, suspended, revoked, or terminated.

History: En. 40-3341 by Sec. 3, Ch. 144, L. 1975; R.C.M. 1947, 40-3341; amd. Sec. 36, Ch. 713, L. 1989; amd. Sec. 52, Ch. 379, L. 1995; amd. Sec. 20, Ch. 380, L. 2003; amd. Sec. 17, Ch. 469, L. 2005; amd. Sec. 14, Ch. 169, L. 2013.

33-17-504. Issuing license — limitations. The commissioner may issue a consultant license to an individual who has complied with the requirements of this chapter with respect to either life insurance, meaning all of those kinds of insurance authorized in 33-1-207, 33-1-208, 33-20-1001, 33-21-103, 33-22-501, and 33-22-601, or general insurance, meaning all of those kinds of insurance authorized in 33-1-206, 33-1-207, 33-1-209 through 33-1-212, 33-1-214 through 33-1-219, and 33-1-221 through 33-1-229, as specified in the license.

History: En. 40-3342 by Sec. 4, Ch. 144, L. 1975; R.C.M. 1947, 40-3342; amd. Sec. 13, Ch. 467, L. 1981; amd. Sec. 37, Ch. 713, L. 1989; amd. Sec. 19, Ch. 427, L. 2003.

33-17-505. Qualification examination — background examination. (1) (a) In order to determine the competency of an applicant for a consultant license, the commissioner shall require the applicant to pass an examination.

(b) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by 33-17-503. The commissioner may arrange for the testing service to recover its cost of the examination from the applicant.

(2) The applicant shall submit to a licensing background examination that meets the requirements provided in 33-17-220.

History: En. 40-3343 by Sec. 5, Ch. 144, L. 1975; amd. Sec. 1, Ch. 146, L. 1977; R.C.M. 1947, 40-3343; amd. Sec. 1, Ch. 324, L. 1987; amd. Sec. 38, Ch. 713, L. 1989; amd. Sec. 15, Ch. 316, L. 1999; amd. Sec. 33, Ch. 472, L. 1999; amd. Sec. 15, Ch. 169, L. 2013.

33-17-506. Repealed. Sec. 29, Ch. 399, L. 2007.

History: En. 40-3344 by Sec. 6, Ch. 144, L. 1975; R.C.M. 1947, 40-3344(part); amd. Sec. 39, Ch. 713, L. 1989.

33-17-507. Repealed. Sec. 29, Ch. 399, L. 2007.

History: En. 40-3344 by Sec. 6, Ch. 144, L. 1975; R.C.M. 1947, 40-3344(part); amd. Sec. 40, Ch. 713, L. 1989; amd. Sec. 34, Ch. 472, L. 1999.

33-17-508 through 33-17-510 reserved.

33-17-511. Consideration for services only on written memorandum. A person licensed as an insurance consultant under this part may not receive a fee for examining, appraising, reviewing, or evaluating an insurance policy, a bond, an annuity, or a pension or profit-sharing contract, plan, or program or for making recommendations or giving advice with regard to any of the above unless the compensation is based upon a written memorandum that includes the insurance consultant's Montana insurance license number, is signed by the party to be charged, and specifies or clearly defines services to be provided and the amount or extent of the compensation. An insurance consultant shall retain a copy of every memorandum or contract for not less than 3 years after those services have been fully performed.

History: En. 40-3345 by Sec. 7, Ch. 144, L. 1975; R.C.M. 1947, 40-3345; amd. Sec. 41, Ch. 713, L. 1989; amd. Sec. 21, Ch. 380, L. 2003; amd. Sec. 7, Ch. 399, L. 2007.

33-17-512. Limitation on type of consideration. A licensed insurance consultant may not receive a commission, service fee, brokerage fee, or other valuable consideration for the sale or service of a line of insurance, annuity, security, or pension trust if the consultant has received compensation from the client for consulting services on the same line of insurance, annuity, security, or pension trust sold or serviced within the preceding 12 months.

History: En. 40-3346 by Sec. 8, Ch. 144, L. 1975; R.C.M. 1947, 40-3346; amd. Sec. 42, Ch. 713, L. 1989; amd. Sec. 1, Ch. 215, L. 1993.

33-17-513. Restrictions on insurers recommended by licensee. A person licensed as an insurance consultant under this part may not recommend or encourage the purchase of insurance, annuities, or securities from an authorized insurer in which the person or any member of the person's immediate family holds an executive position or holds a substantial interest.

History: En. 40-3347 by Sec. 9, Ch. 144, L. 1975; R.C.M. 1947, 40-3347; amd. Sec. 43, Ch. 713, L. 1989; amd. Sec. 1205, Ch. 56, L. 2009.

Part 6
Administrators

Part Cross-References

Licenses — discrimination in issuance prohibited, 49-3-204.

33-17-601. Repealed. Sec. 68, Ch. 713, L. 1989.

History: En. Sec. 1, Ch. 343, L. 1979; amd. Sec. 10, Ch. 409, L. 1987.

33-17-602. Written agreement required. (1) A person may not act as an administrator without a written agreement between the person and the insurer. The written agreement must be retained as part of the official records of both the administrator and the insurer for the duration of the agreement and for 5 years thereafter. The written agreement must contain provisions that include the requirements of 33-17-612 through 33-17-617 insofar as these requirements relate to the functions performed by the administrator.

(2) The agreement must contain a provision with respect to the underwriting or other standards pertaining to the business underwritten by the insurer.

(3) Whenever a policy is issued to a trustee, a copy of the trust agreement and any amendments to it must be furnished to the insurer by the administrator and be retained as part of the official records of both the administrator and the insurer for the duration of the policy and for 5 years thereafter.

History: En. Sec. 2, Ch. 343, L. 1979; amd. Sec. 11, Ch. 409, L. 1987; amd. Sec. 44, Ch. 713, L. 1989.

33-17-603. Certificate of registration. (1) Except as provided in 33-17-604, a person may not act as or represent to the public that the person is an administrator in this state unless the person holds a certificate of registration as an administrator.

(2) An application for a certificate of registration must be accompanied by a fee of $100. The commissioner shall issue the certificate unless the commissioner finds that the applicant is not competent, trustworthy, financially responsible, or of good personal and business reputation or that the applicant has had a previous application for a license denied for cause within 5 years.

(3) A certificate of registration must be renewed each year by the administrator paying a continuation fee of $100 on or before July 1. Upon payment, the certificate continues in force unless suspended, revoked, or otherwise terminated. The commissioner shall deposit the fee with the state treasurer to be credited to the general fund.

(4) A certificate of registration may be suspended or revoked if, after notice and hearing, the commissioner finds that the administrator has violated any of the requirements of this part or that the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

(5) Unless a certification requirement is waived, a person who acts as an administrator without a certificate of registration is subject to a fine of not less than $500 or more than $1,500.

History: En. Sec. 12, Ch. 343, L. 1979; amd. Sec. 45, Ch. 713, L. 1989; amd. Sec. 8, Ch. 798, L. 1991; amd. Sec. 53, Ch. 379, L. 1995; amd. Sec. 148, Ch. 42, L. 1997.

Cross-References

Hearings on decisions of Commissioner, 33-1-701.

Former criminal offenders — consideration in licensing, 37-1-203.

33-17-604. Waiver of certification requirements. The commissioner may waive the requirements of 33-17-603 for any person or class of persons. The factors taken into account in granting a waiver include but are not limited to:

(1) whether the person acting as an administrator is primarily in a business other than that of administrator;

(2) whether the financial strength and history of the organization indicates stability in its continuity of doing business;

(3) whether the regular duties being performed as an administrator are such that the covered persons are not likely to be injured by a waiver of the requirements.

History: En. Sec. 13, Ch. 343, L. 1979; amd. Sec. 46, Ch. 713, L. 1989.

33-17-605. Repealed. Sec. 19, Ch. 409, L. 1987.

History: En. Sec. 10, Ch. 343, L. 1979.

33-17-606 through 33-17-610 reserved.

33-17-611. Maintenance of information. For the duration of the agreement required by 33-17-602 and for 5 years thereafter, each administrator shall maintain at its principal administrative office adequate books and records of all transactions between the administrator, insurers, and insured persons. These books and records must be maintained in accordance with prudent standards of insurance recordkeeping. The commissioner shall have access to these books and records for examination, audit, or inspection. Any trade secrets contained in the books and records, including but not limited to the identity and addresses of policyholders and certificate holders, are confidential, except that the commissioner may use the information in any proceedings instituted against the administrator. The insurer retains the right to continuing access to those books and records of the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and the administrator.

History: En. Sec. 3, Ch. 343, L. 1979; amd. Sec. 47, Ch. 713, L. 1989.

33-17-612. Approval of advertising. An administrator may use only such advertising pertaining to the business underwritten by an insurer as is approved by the insurer in advance of its use.

History: En. Sec. 4, Ch. 343, L. 1979.

33-17-613. Collection of charges and premiums. (1) All insurance charges or premiums collected by an administrator on behalf of or for an insurer and return premiums received from the insurer are held by the administrator in a fiduciary capacity. These funds must be immediately remitted to the person entitled to them or must be deposited promptly in a fiduciary bank account established and maintained by the administrator. If deposited charges or premiums were collected on behalf of or for more than one insurer, the administrator shall require the bank in which the fiduciary account is maintained to keep records clearly recording the deposits in and withdrawals from the account on behalf of or for each insurer. The administrator shall promptly obtain and keep copies of all these records and, upon request of an insurer, shall furnish the insurer with copies of the records pertaining to deposits and withdrawals on behalf of or for the insurer.

(2) The administrator may not pay a claim by withdrawals from the fiduciary account. Withdrawals from the fiduciary account must be made, as provided in the written agreement between the administrator and the insurer, for:

(a) remittance to an insurer entitled to the remittance;

(b) deposit in an account maintained in the name of the insurer;

(c) transfer to and deposit in a claims paying account, with claims to be paid as provided in 33-17-615;

(d) payment to a group policyholder for remittance to the insurer entitled to the payment;

(e) payment to the administrator of its commission, fees, or charges; or

(f) remittance of return premiums to the person entitled to the premium.

History: En. Sec. 5, Ch. 343, L. 1979; amd. Sec. 48, Ch. 713, L. 1989.

Cross-References

Duties of trustees, Title 72, ch. 38, part 8.

33-17-614. Treatment of payments. Whenever an insurer utilizes the services of an administrator under the terms of a written contract as required in 33-17-602, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured is considered to be received by the insurer and the payment of return premiums or claims by the insurer to the administrator is not considered payment to the insured or claimant until the payments are received by the insured or claimant. This section does not limit any right of the insurer against the administrator resulting from the administrator's failure to make payments to the insurer, insureds, or claimants.

History: En. Sec. 6, Ch. 343, L. 1979.

33-17-615. Payment of claims. All claims paid by the administrator from funds collected on behalf of the insurer shall be paid only on drafts of and as authorized by such insurer.

History: En. Sec. 7, Ch. 343, L. 1979.

33-17-616. Delivery of documents. Any policies, certificates, booklets, termination notices, or other written communications delivered by the insurer to the administrator for delivery to its policyholders shall be delivered by the administrator promptly after receipt of instructions from the insurer to do so.

History: En. Sec. 8, Ch. 343, L. 1979.

33-17-617. Claim adjustment and settlement. With respect to any policies where an administrator adjusts or settles claims, the compensation to the administrator with regard to the policies shall in no way be contingent on claim experience. This section does not prevent the compensation of an administrator from being based on premiums or charges collected or number of claims paid or processed.

History: En. Sec. 9, Ch. 343, L. 1979.

33-17-618. Insured persons to be notified of availability of administrator. Whenever the services of an administrator are utilized, the administrator shall provide a written notice, approved by the insurer, to insured individuals, advising them of the identity of and relationship between the administrator, the policyholder, and the insurer. Whenever an administrator collects funds, the administrator shall identify and state, separately in writing, to the person paying to the administrator any charge or premium for insurance coverage the amount of such charge or premium specified by the insurer for the insurance coverage.

History: En. Sec. 11, Ch. 343, L. 1979.

Parts 7 through 9 reserved

Part 10

Revocation, Suspension, and Penalties

33-17-1001. Suspension, revocation, or refusal of license. (1) The commissioner may suspend, revoke, refuse to renew, or refuse to issue a license under this chapter, may levy a civil penalty in accordance with 33-1-317, or may choose any combination of actions when a licensee or applicant for licensure has:

(a) engaged or is about to engage in an act or practice for which issuance of the license could have been refused;

(b) obtained or attempted to obtain a license through misrepresentation or fraud, including but not limited to providing incorrect, misleading, incomplete, or materially untrue information in the license application or in the continuing education affidavit;

(c) violated or failed to comply with a provision of this code or has violated a rule, subpoena, or order of the commissioner or of the commissioner of any other state;

(d) improperly withheld, misappropriated, or converted to the licensee's or applicant's own use money or property belonging to policyholders, insurers, beneficiaries, or others and received in conduct of business under the license;

(e) been convicted of a felony;

(f) in the conduct of the affairs under the license, used fraudulent, coercive, or dishonest practices or the licensee or applicant is incompetent, untrustworthy, financially irresponsible, or a source of injury and loss to the public;

(g) misrepresented the terms of an actual or proposed insurance contract or application for insurance;

(h) been found guilty of an unfair trade practice or fraud prohibited by Title 33, chapter 18;

(i) had a similar license denied, suspended, or revoked in any other state;

(j) forged another's name to an application for insurance or to any document related to an insurance transaction;

(k) cheated on an examination for a license;

(l) knowingly accepted insurance business from a person who is not licensed;

(m) failed to comply with a final administrative or court order imposing a child support obligation; or

(n) failed to pay state income tax determined to be delinquent or to comply with any final administrative or court order directing payment of state income tax.

(2) The license of a business entity may be suspended, revoked, refused, or denied if a reason listed in subsection (1) applies to an individual designated in the license to exercise its powers.

(3) The commissioner retains the authority to enforce the provisions of and impose any penalty or remedy authorized by the insurance code against any person who is under investigation for or charged with a violation of the insurance code even if the person's license or registration has been surrendered, suspended, revoked, refused, or denied or has lapsed.

History: En. Sec. 173, Ch. 286, L. 1959; R.C.M. 1947, 40-3329; amd. Sec. 6, Ch. 395, L. 1983; amd. Sec. 12, Ch. 409, L. 1987; amd. Sec. 28, Ch. 537, L. 1987; amd. Sec. 49, Ch. 713, L. 1989; amd. Sec. 2, Ch. 164, L. 1993; amd. Sec. 8, Ch. 622, L. 1993; amd. Sec. 45, Ch. 227, L. 2001; amd. Sec. 20, Ch. 427, L. 2003; amd. Sec. 14, Ch. 271, L. 2009; amd. Sec. 7, Ch. 313, L. 2009; amd. Sec. 7, Ch. 139, L. 2015.

Cross-References

Termination of criminal's supervision — restoration of rights, Art. II, sec. 28, Mont. Const.
Revocation of surplus lines insurance producer's license, 33-2-313.
Former criminal offenders — consideration in licensing, 37-1-203.
Felony — definition, 45-2-101.

33-17-1002. Procedure following suspension or revocation. (1) Upon suspension, revocation, or refusal of a license, the commissioner shall notify the licensee or applicant by mail addressed to the licensee or applicant at the last-known address contained in the records of the commissioner. Notice is effectuated when mailed.

(2) The commissioner may reissue a license that has lapsed if the licensee has paid the lapsed license reinstatement fee pursuant to 33-2-708 and has filed certification of completion of continuing education requirements for the preceding biennium within 1 year of the lapse occurring.

(3) The commissioner may not again issue a license under this code to a person whose license has been revoked until after expiration of 1 year and until the person again qualifies for a license in accordance with this code. If the commissioner revokes a person's license, the commissioner may refuse to issue a license to the person for up to 5 years after the revocation. A person whose license has been revoked twice is not again eligible for any license under this code.

(4) If the license of a business entity is suspended or revoked, a member, officer, or director of the business entity may not be licensed or be designated in a license to exercise the business entity's powers during the period of the suspension or revocation unless the commissioner determines upon substantial evidence that the member, officer, or director was not personally at fault and did not acquiesce in the matter on account of which the license was suspended or revoked.

History: En. Sec. 174, Ch. 286, L. 1959; R.C.M. 1947, 40-3330; amd. Sec. 13, Ch. 409, L. 1987; amd. Sec. 50, Ch. 713, L. 1989; amd. Sec. 21, Ch. 427, L. 2003; amd. Sec. 15, Ch. 271, L. 2009; amd. Sec. 8, Ch. 139, L. 2015.

33-17-1003. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 175, Ch. 286, L. 1959; R.C.M. 1947, 40-3331; amd. Sec. 51, Ch. 713, L. 1989.

33-17-1004. Acting without license. In addition to the requirements and penalties described in 33-17-201 and 33-17-411, a person who, in this state, acts without having authority to do so by virtue of a license issued and in force pursuant to this chapter is subject to the provisions of 33-1-317 and 33-1-318.

History: En. 40-3332 by Sec. 1, Ch. 256, L. 1967; R.C.M. 1947, 40-3332; amd. Sec. 22, Ch. 198, L. 1979; amd. Sec. 7, Ch. 395, L. 1983; amd. Sec. 14, Ch. 409, L. 1987; amd. Sec. 52, Ch. 713, L. 1989; amd. Sec. 6, Ch. 493, L. 2003; amd. Sec. 9, Ch. 139, L. 2015; amd. Sec. 26, Ch. 396, L. 2017.

33-17-1005. Restrictions on acting as legal guardian of insured or policyholder. (1) Except as otherwise approved by the commissioner or court order, an insurance producer may not act as a legal guardian of an insured or policyholder if the insurance producer conducts insurance business with the insured or policyholder when the insurance business includes but is not limited to the solicitation, offer, sale, or replacement of insurance or a contract.

(2) This section does not apply to immediate family members.

History: En. Sec. 1, Ch. 493, L. 2003.

Part 11
Conduct of Business by Insurance Producers

33-17-1101. Place of business — display of license — records. (1) A resident insurance producer shall maintain a place or places of business in this state accessible to the public. A nonresident insurance producer may maintain a place or places of business in this state. An insurance producer's place or places of business must be a place in which transactions are conducted under the insurance producer's license. The address of the primary place of business must appear on the license. This section does not prohibit the maintenance of a place of business in a licensee's place of residence.

(2) The license or, if the insurance producer has more than one place of business, a copy of the license must be conspicuously displayed in a part of the place of business customarily open to the public.

(3) On request, resident and nonresident insurance producers are required to identify themselves and provide their license number to persons with whom they sell, solicit, or negotiate insurance.

(4) The insurance producer shall keep at a place of business complete records pertaining to transactions under the license for a period of at least 3 years after completion of the respective transactions, except that a title insurance producer, as defined in 33-25-105, shall retain records as provided in 33-25-214 and 33-25-216.

History: En. Sec. 167, Ch. 286, L. 1959; R.C.M. 1947, 40-3323; amd. Sec. 10, Ch. 345, L. 1979; amd. Sec. 20, Ch. 519, L. 1985; amd. Sec. 15, Ch. 409, L. 1987; amd. Sec. 53, Ch. 713, L. 1989; amd. Sec. 1, Ch. 261, L. 1997; amd. Sec. 16, Ch. 169, L. 2013; amd. Sec. 18, Ch. 157, L. 2023.

33-17-1102. Reporting and accounting for premiums — misappropriation. (1) All insurance premiums or return premiums received by an insurance producer must be held in a separate trust account. The insurance producer shall at all times act in a fiduciary capacity and shall, in the applicable regular course of business, account for and pay the insurance premiums or return premiums the insurance producer receives to the insured, insurer, or insurance producer entitled to them. Except for a title insurance producer as defined in 33-25-105, an insurance producer may deposit and commingle in the same separate deposit all funds belonging to others so long as the amount of the deposit held for each respective person is reasonably ascertainable from the records and accounts of the licensee.

(2) Any insurance producer not lawfully entitled to the funds may not divert or appropriate the funds or any portion of the funds to the insurance producer's own use.

History: En. Sec. 168, Ch. 286, L. 1959; amd. Sec. 51, Ch. 359, L. 1977; R.C.M. 1947, 40-3324; amd. Sec. 21, Ch. 519, L. 1985; amd. Sec. 16, Ch. 409, L. 1987; amd. Sec. 54, Ch. 713, L. 1989; amd. Sec. 22, Ch. 380, L. 2003; amd. Sec. 27, Ch. 396, L. 2017.

Cross-References

Duties of trustees, Title 72, ch. 38, part 8.

33-17-1103. Accepting and paying commissions, fees, or consideration. (1) An insurer or insurance producer may not pay, directly or indirectly, a commission, service fee, brokerage fee, or other valuable consideration to a person for services as an insurance producer unless the person performing the service holds a valid license with regard to the kind or kinds of insurance for which the service was rendered at the time the service was performed. A person not properly licensed in accordance with this chapter at the time the person performs the service as an insurance producer may not accept a commission, service fee, brokerage fee, or other valuable consideration for the service. This section does not prevent payment or receipt of renewal or other deferred commissions to or by a person entitled to receive the payment under this section.

(2) An insurance producer may not directly or indirectly share the insurance producer's commissions or other compensation received or to be received by the insurance producer on account of a transaction under the insurance producer's license with any person not also licensed under this chapter as to the same kind or kinds of insurance involved in the transactions. This provision does not affect payment of the regular salaries due to employees of the licensee, the distribution in regular course of business of compensation and profits among members or stockholders if the licensee is a business entity, or use of funds for family or personal purposes.

(3) Surplus lines producers may share commissions with a property and casualty insurance producer pursuant to 33-2-306.

History: En. Sec. 169, Ch. 286, L. 1959; R.C.M. 1947, 40-3325; amd. Sec. 11, Ch. 345, L. 1979; amd. Sec. 17, Ch. 409, L. 1987; amd. Sec. 55, Ch. 713, L. 1989; amd. Sec. 46, Ch. 227, L. 2001; amd. Sec. 8, Ch. 399, L. 2007; amd. Sec. 16, Ch. 271, L. 2009.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-17-1104. Repealed. Sec. 68, Ch. 713, L. 1989.

History: En. Sec. 170, Ch. 286, L. 1959; R.C.M. 1947, 40-3326; amd. Sec. 18, Ch. 409, L. 1987.

33-17-1105 and 33-17-1106 reserved.

33-17-1107. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 1, Ch. 699, L. 1991.

33-17-1108 through 33-17-1110 reserved.

33-17-1111. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 67, Ch. 286, L. 1959; amd. Sec. 1, Ch. 72, L. 1963; R.C.M. 1947, 40-2822; amd. Sec. 12, Ch. 345, L. 1979; amd. Sec. 2, Ch. 395, L. 1983; amd. Sec. 56, Ch. 713, L. 1989.

33-17-1112. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 68, Ch. 286, L. 1959; R.C.M. 1947, 40-2823; amd. Sec. 57, Ch. 713, L. 1989.

33-17-1113. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 69, Ch. 286, L. 1959; R.C.M. 1947, 40-2824; amd. Sec. 58, Ch. 713, L. 1989.

33-17-1114. Repealed. Sec. 73, Ch. 227, L. 2001.

History: En. Sec. 70, Ch. 286, L. 1959; R.C.M. 1947, 40-2825; amd. Sec. 59, Ch. 713, L. 1989.

Part 12
Insurance Producer and Consultant Continuing Education Act

33-17-1201. Short title. This part may be cited as the "Insurance Producer, Adjuster, and Consultant Continuing Education Act".

History: En. Sec. 1, Ch. 622, L. 1993; amd. Sec. 1, Ch. 38, L. 2005.

33-17-1202. Purpose. The purposes of this part are to:

(1) protect insurance consumers and dedicated insurance producers, adjusters, public adjusters, and consultants by requiring continuing education for insurance producers, adjusters, public adjusters, and consultants;

(2) better educate insurance producers, adjusters, public adjusters, and consultants about changes in insurance law, products, ethical conduct as an insurance producer, adjuster, or consultant, marketing, and management; and

(3) provide standards for the qualification of instructors, courses, and materials.

History: En. Sec. 2, Ch. 622, L. 1993; amd. Sec. 2, Ch. 38, L. 2005; amd. Sec. 10, Ch. 139, L. 2015.

33-17-1203. Continuing education — basic requirements — exceptions. (1) Unless exempt under subsection (3):

(a) an individual licensed to act as an insurance producer, adjuster, public adjuster, or consultant other than an individual licensed only for surety bail bonds or for limited lines credit insurance shall, during each 24-month period, complete at least 24 credit hours of approved continuing education, including at least 3 hours of ethics credits and at least 1 credit hour on changes in Montana insurance statutes and administrative rules;

(b) an individual licensed to act as an insurance producer only for surety bail bonds, prepaid legal insurance, or limited lines credit insurance shall, during each biennium, complete 5 credit hours of approved continuing education, including at least 1 credit hour on changes in Montana insurance statutes and administrative rules and the remaining credit hours in the areas of insurance law, ethics, or topics specific to surety bail bonds, prepaid legal insurance, or limited lines credit insurance.

(2) The commissioner may, for good cause, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

(3) The minimum continuing education requirements do not apply to:

(a) an individual holding a temporary license issued under 33-17-216; or

(b) an insurance producer, adjuster, public adjuster, or consultant otherwise exempted by the commissioner.

History: En. Sec. 3, Ch. 622, L. 1993; amd. Sec. 2, Ch. 98, L. 1995; amd. Sec. 1, Ch. 456, L. 1997; amd. Sec. 27, Ch. 531, L. 1997; amd. Sec. 35, Ch. 472, L. 1999; amd. Sec. 37, Ch. 7, L. 2001; amd. Sec. 7, Ch. 106, L. 2001; amd. Sec. 22, Ch. 427, L. 2003; amd. Sec. 3, Ch. 38, L. 2005; amd. Sec. 18, Ch. 469, L. 2005; amd. Sec. 8, Ch. 313, L. 2009; amd. Sec. 1, Ch. 398, L. 2009; amd. Sec. 2, Ch. 324, L. 2013; amd. Sec. 11, Ch. 139, L. 2015.

33-17-1204. Review and approval of continuing education courses by commissioner. (1) The commissioner shall approve only those continuing education courses, lectures, seminars, and instructional programs that the commissioner determines would improve the product knowledge, management, ethics, or marketing capability of the licensee. Course content, instructors, material, instructional format, and the sponsoring organization must be approved and periodically reviewed by the commissioner. The fee for approval of a course, lecture, seminar, or instructional program is listed in 33-2-708(2). The commissioner shall also determine the number of credit hours to be awarded for completion of an approved continuing education activity.

(2) The commissioner may enter into a contract with a person to review and recommend for approval continuing education courses, lectures, seminars, and instructional programs that the commissioner determines would improve the product knowledge, management, ethics, or marketing capability of the licensee.

(3) In conducting periodic review of course content, instructors, material, instructional format, or a sponsoring organization, the commissioner may exercise any investigative power of the commissioner provided for in 33-1-311 or 33-1-315.

(4) If after review or investigation the commissioner determines an approved continuing education activity is not being operated in compliance with the standards established under this section, the commissioner may revoke approval, place the activity under probationary approval, or issue a cease and desist order under 33-1-318.

History: En. Sec. 4, Ch. 622, L. 1993; amd. Sec. 16, Ch. 316, L. 1999; amd. Sec. 47, Ch. 227, L. 2001; amd. Sec. 23, Ch. 380, L. 2003; amd. Sec. 4, Ch. 38, L. 2005; amd. Sec. 17, Ch. 271, L. 2009; amd. Sec. 1, Ch. 7, L. 2023.

33-17-1205. Compliance — failure to comply — rulemaking authority. (1) Each individual subject to the requirements of 33-17-1203 shall file biennially in a format supplied by the commissioner certification as to the approved courses, lectures, seminars, and instructional programs successfully completed by that individual during the preceding biennium.

(2) If an individual fails to comply with this section, the individual's license lapses. An individual with a lapsed license may not conduct insurance business under another person's license, including a business entity license affiliation.

(3) In the continuing education affidavit, an insurance producer, adjuster, or public adjuster shall report to the commissioner the final disposition of any administrative action or the final disposition of any criminal action taken against the insurance producer, adjuster, or public adjuster in another jurisdiction or by another governmental agency in this state. As used in this subsection, "final disposition of any criminal action" means a plea agreement or sentence and judgment.

(4) Each person providing approved courses, lectures, seminars, and instructional programs, including insurance company education programs, shall file annually with the commissioner an alphabetical list of the names and addresses of all individuals who have successfully completed an approved continuing education activity during the preceding calendar year.

(5) The commissioner may, following the process provided for in 33-1-314, withdraw approval of all courses, lectures, seminars, and instructional programs of any person that fails to comply with subsection (4). The commissioner may, after having conducted a hearing pursuant to 33-1-701, impose a fine upon a person that has failed to comply with subsection (4). The fine may not exceed the penalty permitted by 33-1-317.

(6) The commissioner may adopt rules establishing the requirements for biennial filing and reporting of continuing education credits.

History: En. Sec. 5, Ch. 622, L. 1993; amd. Sec. 17, Ch. 316, L. 1999; amd. Sec. 23, Ch. 427, L. 2003; amd. Sec. 5, Ch. 38, L. 2005; amd. Sec. 19, Ch. 469, L. 2005; amd. Sec. 12, Ch. 139, L. 2015.

33-17-1206. Rulemaking authority. The commissioner may adopt rules to implement this part.

History: En. Sec. 6, Ch. 622, L. 1993.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-17-1207. Funding for continuing education program. All continuing education filing fees collected by the commissioner and fees paid to the commissioner for the review of initial applications for approval of continuing education courses or the periodic review of these courses must be turned over promptly to the state treasurer who shall place the money in the state special revenue fund to the credit of the state auditor's office to be used for the continuing education program. The funds allocated by this section to the state special revenue fund may be used only to defray the expenses of the state auditor's office in discharging its duties as prescribed by this part, subject to the applicable laws relating to the appropriation of state funds and to the deposit and expenditure of state money. The state auditor is responsible for the proper expenditure of this money as provided by law.

History: En. Sec. 9, Ch. 622, L. 1993; amd. Sec. 24, Ch. 427, L. 2003.

Part 13 reserved

Part 14
Travel Insurance

33-17-1401. Definitions. As used in this part, the following definitions apply:

(1) "Aggregator site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(2) "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(3) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the non-refundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance.

(4) "Commissioner" means the commissioner of insurance of the state of Montana.

(5) "Eligible group" means, for the purpose of travel insurance, two or more persons who are engaged in a common enterprise or have an economic, educational, or social affinity or relationship, including but not limited to any of the following:

(a) any entity engaged in the business of providing travel or travel services, including but not limited to tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, cultural exchange programs, and common carriers or the operator, owner, or lessor of a means of transportation of passengers, including but not limited to airlines, cruise lines, railroads, steamship companies, and public bus carriers, wherein with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to the travel;

(b) any college, school, or other institution of learning, covering students, teachers, employees, or volunteers;

(c) any employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests;

(d) any sports team, camp, or sponsor thereof, covering participants, members, campers, employees, officials, supervisors, or volunteers;

(e) any religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants, or volunteers;

(f) any financial institutions or financial institution vendor or parent holding company, trustee, or agent of or designated by one or more financial institutions or financial institution vendors, including accountholders, credit card holders, debtors, guarantors, or purchasers;

(g) any incorporated or unincorporated association, including labor unions, having a common interest, constitution, and bylaws and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of the association covering its members;

(h) any trust or the trustees of a fund established, created, or maintained for the benefit of and covering members, employees, or customers, subject to the commissioner's permitting the use of a trust and the state's premium tax provisions in 33-2-705 of one or more associations meeting the requirements in subsection (5)(g);

(i) any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

(j) any volunteer fire department, ambulance, rescue, police, or court or any first aid, civil defense, or other volunteer group;

(k) preschools, daycare institutions for children or adults, and senior citizen clubs;

(l) any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles. The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company is the policyholder under a policy to which this section applies.

(m) any other group for which the commissioner has determined that the members are engaged in a common enterprise or have an economic, educational, or social affinity or relationship and that issuance of the policy would not be contrary to the public interest.

(6) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(7) "Limited lines travel insurance producer" means a:

(a) managing general agent or third-party administrator;

(b) licensed insurance producer, including a limited lines producer, designated by an insurer as the travel insurance supervising entity as set forth in 33-17-1404; or

(c) travel administrator.

(8) "Offer and disseminate" means providing general information, including a description of coverage and price, as well as processing applications, collecting premiums, and performing other activities not requiring licensure by the state.

(9) "Travel administrator" means a person who directly or indirectly underwrites, collects charges, collateral, or premiums from, or adjusts or settles claims on residents of this state in connection with travel insurance, except that a person may not be considered a travel administrator if that person's only actions that would otherwise cause it to be considered a travel administrator are among the following:

(a) a person working for a travel administrator to the extent that the person's activities are subject to the supervision and control of the travel administrator;

(b) an insurance producer selling insurance or engaged in administrative and facilitation of claims-related activities within the scope of the producer's license;

(c) a travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with this part;

(d) an individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage; or

(e) a business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer.

(10) "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event and that do not result in the transfer or shifting of risk that would constitute the business of insurance. Travel assistance services include but are not limited to security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document

replacement assistance; lost luggage assistance; concierge services; and any other service that is furnished in connection with planned travel. Travel assistance services are not insurance and are not related to insurance.

(11) (a) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including but not limited to:

(i) interruption or cancellation of a trip or event;

(ii) loss of baggage or personal effects;

(iii) damages to accommodations or rental vehicles;

(iv) sickness, accident, disability, or death occurring during travel;

(v) emergency evacuation;

(vi) repatriation of remains; or

(vii) any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the commissioner.

(b) The term does not include major medical plans that provide comprehensive medical protection for travelers on trips lasting 6 months or longer, including those working overseas and military personnel being deployed.

(c) Travel insurance must be classified and filed for purposes of rates and forms under an inland marine line of insurance, provided, however, that travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, may be filed under either an accident and health line of insurance or an inland marine line of insurance as long as the insurer is authorized to transact business in the line of insurance under which the rates and forms are filed.

(d) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, provided those standards also meet the state's underwriting standards for inland marine.

(12) "Travel protection plans" means plans that provide one or more of the following:

(a) travel insurance;

(b) travel assistance services; or

(c) cancellation fee waivers.

(13) "Travel retailer" means a business entity that makes, arranges, or offers travel services and that may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

History: **En. Sec. 1, Ch. 359, L. 2013; amd. Sec. 1, Ch. 517, L. 2023.**

33-17-1402. Requirements to offer and disseminate travel insurance — types of policies — rulemaking. (1) The commissioner may issue a limited lines travel insurance producer license to an individual or business entity that has filed with the commissioner an application for a limited lines travel insurance producer license in a form and manner prescribed by the commissioner. The limited lines travel insurance producer must be licensed to sell, solicit, or negotiate travel insurance through a licensed insurer. A person may not act as a limited lines travel insurance producer or travel retailer unless properly licensed or registered, respectively.

(2) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(a) the limited lines travel insurance producer or travel retailer provides purchasers of travel insurance with:

(i) a description of the material terms or the actual material terms of the insurance coverage;

(ii) a description of the process for filing a claim;

(iii) a description of the review or cancellation process for the travel insurance policy; and

(iv) the identity and contact information of the insurer and the limited lines travel insurance producer;

(b) the limited lines travel insurance producer designates an employee who is an individual licensed producer as the designated responsible producer responsible for the limited lines travel insurance producer's compliance with the applicable insurance laws and rules of this state;

(c) the designated responsible producer, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations have complied with the fingerprinting requirements in the resident state of the limited lines travel insurance producer;

(d) the limited lines travel insurance producer has paid all applicable insurance producer licensing fees required pursuant to 33-2-708 or other applicable state law; and

(e) the limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the commissioner. The training material must, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(3) A travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

(a) provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(b) explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(c) explain that a travel retailer employee or authorized representative who is not licensed as an insurance producer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(4) A travel retailer's employees or authorized representatives who are not licensed as insurance producers may not:

(a) evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(b) evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(c) hold themselves out as licensed insurers, licensed producers, or insurance experts.

(5) Travel insurance may be provided under an individual policy or under a group or master policy.

(6) A person licensed in property and casualty as an insurance producer is authorized to sell, solicit, and negotiate travel insurance. A property and casualty insurance producer is not required to become appointed by an insurer in order to sell, solicit, or negotiate travel insurance.

History: En. Sec. 2, Ch. 359, L. 2013; amd. Sec. 2, Ch. 517, L. 2023; amd. Sec. 15, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 15, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-17-1403. Authorization. Upon a limited lines travel insurance producer meeting the requirements provided for in 33-17-1402, a travel retailer is authorized to offer and disseminate travel insurance and receive related compensation when the travel retailer's insurance-related activities and those of its employees and authorized representatives are limited to offering and disseminating travel insurance on behalf of and under the direction of the limited lines travel insurance producer.

History: En. Sec. 3, Ch. 359, L. 2013.

33-17-1404. Responsibility — enforcement — penalties — scope. (1) The limited lines travel insurance producer is the supervising entity responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with the provisions of this part.

(2) A limited lines travel insurance producer and any travel retailer offering and disseminating travel insurance under the limited lines travel insurance producer's license are subject to the enforcement provisions applicable to insurance producers generally.

(3) All other applicable provisions of the insurance code continue to apply to travel insurance, except that the specific provisions of this part supersede any general provisions of law that would otherwise be applicable to travel insurance.

History: En. Sec. 4, Ch. 359, L. 2013; amd. Sec. 3, Ch. 517, L. 2023.

33-17-1405. Travel protection plans. Travel protection plans may be offered for one price for the combined features that the travel protection plan offers in this state if:

(1) the travel protection plan clearly discloses to the consumer, at or prior to the time of purchase, that it includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity, at or prior to the time of purchase, for the consumer to obtain additional information regarding the features and pricing of each; and

(2) the fulfillment materials:

(a) describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(b) include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

History: En. Sec. 4, Ch. 517, L. 2023.

33-17-1406. Sales practices. (1) All persons offering travel insurance to residents of this state are subject to the provisions of the unfair trade practice provisions of Title 33, chapter 18, except as otherwise provided in this section. In the event of a conflict between this part and other provisions of Title 33 regarding the sale and marketing of travel insurance and travel protection plans, the provisions of this part control.

(2) Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under Title 33, chapter 18.

(3) The marketing of a travel insurance policy must meet the following requirements:

(a) All documents provided to consumers prior to the purchase of travel insurance, including but not limited to sales materials, advertising materials, and marketing materials, must be consistent with the travel insurance policy itself, including but not limited to forms, endorsements, policies, rate filings, and certificates of insurance.

(b) For travel insurance policies or certificates that contain preexisting condition exclusions, information and an opportunity to learn more about the preexisting condition exclusions must be provided any time prior to the time of purchase and included in the coverage's fulfillment materials.

(c) (i) The fulfillment materials and the information described in 33-17-1402(2)(a)(i) through (2)(a)(iv) must be provided to a policyholder or certificate holder as soon as practicable following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

(A) 15 days following the date of delivery of the travel protection plan's fulfillment materials by postal mail; or

(B) 10 days following the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

(ii) For the purposes of subsection (3)(c)(i), "delivery" means handing fulfillment materials to the policyholder or certificate holder or sending fulfillment materials by postal mail or electronic means to the policyholder or certificate holder.

(d) The company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(e) When travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it is not an unfair trade practice or other violation of law if an accurate summary or short description of coverage is provided on the web page and as long as the consumer has access to the full provisions of the policy through electronic means.

(4) A person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis may not do so by using negative option or opt out, which would require a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form, when the consumer purchases a trip.

(5) It is an unfair trade practice to market blanket travel insurance coverage as free.

(6) When a consumer's destination jurisdiction requires insurance coverage, it is not an unfair trade practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(a) purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

(b) agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

History: En. Sec. 5, Ch. 517, L. 2023.

33-17-1407. Travel administrators. (1) A person may not act or represent itself as a travel administrator for travel insurance in this state unless the person:

(a) is a licensed property and casualty insurance producer in this state for activities permitted under the producer's license; or

(b) holds a valid third-party administrator certificate in this state.

(2) A travel administrator and its employees are exempt from the licensing requirements of Title 33, chapter 17, part 3, for travel insurance it administers.

(3) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer and is responsible for ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the commissioner on request.

History: En. Sec. 6, Ch. 517, L. 2023.

33-17-1408. Rulemaking. The commissioner may adopt rules necessary to implement the provisions of this part.

History: En. Sec. 7, Ch. 517, L. 2023.

Part 15
Rental Vehicle Insurance

33-17-1501. Definitions. As used in this part, the following definitions apply:

(1) "Customer service representative" means an employee of a rental vehicle entity.

(2) "Present rental vehicle insurance information" means to present the option to acquire rental vehicle insurance to a renter.

(3) "Rental agreement" means a written agreement setting forth the terms and conditions governing the use of a vehicle that is provided by a rental vehicle entity for the rental or lease of a rental vehicle for a period of not more than 90 days.

(4) "Rental vehicle" means a motor vehicle that is designated as:

(a) a private passenger motor vehicle, including an automobile, a passenger van, a minivan, or a sport utility vehicle; or

(b) a cargo vehicle, including a cargo van, a pickup truck, or a truck with a gross weight of less than 26,000 pounds that does not require the operator to possess a commercial driver's license.

(5) "Rental vehicle entity" means an entity in the business of providing rental vehicles to the public under a rental agreement.

(6) "Rental vehicle insurance" means insurance that a renter purchases from a rental vehicle entity as part of the rental agreement in conjunction with the use of a rental vehicle.

(7) "Renter" means a person who obtains the use of a rental vehicle from a rental vehicle entity under the terms of a rental agreement.

History: En. Sec. 1, Ch. 409, L. 2003.

33-17-1502. Rental vehicle entity license — customer service representative requirements — recordkeeping. (1) A rental vehicle entity may obtain a business entity insurance producer license.

(2) A rental vehicle entity shall designate an individual licensed insurance producer who is responsible for the rental vehicle entity's compliance with the insurance laws of this state.

(3) A rental vehicle entity or customer service representative may not present rental vehicle insurance information to renters unless the rental vehicle entity is licensed and the customer service representative has been trained as required under 33-17-1503.

(4) A customer service representative may present rental vehicle insurance information only on behalf of a rental vehicle entity.

(5) A rental vehicle entity shall supervise a customer service representative who provides rental vehicle insurance under the provisions of this part.

(6) A rental vehicle entity shall submit to the commissioner an annual report listing each customer service representative presenting rental vehicle insurance information to the public.

History: **En. Sec. 2, Ch. 409, L. 2003; amd. Sec. 20, Ch. 469, L. 2005; amd. Sec. 14, Ch. 63, L. 2015.**

33-17-1503. Training of customer service representative. (1) A rental vehicle entity shall provide a training program for each customer service representative prior to allowing that customer service representative to present rental vehicle insurance information to renters.

(2) The rental vehicle entity shall present the training program to the commissioner for approval.

(3) The training may be in an electronic or video format and must cover the following areas:

(a) rental vehicle insurance;

(b) specific instruction that information may not be presented either by statement or conduct, express or implied, that would lead the renter to believe:

(i) that the purchase of rental vehicle insurance is required to rent a vehicle;

(ii) that the renter does not have a personal automobile insurance policy in place that provides coverage; or

(iii) that the customer service representative is qualified to evaluate the adequacy of the renter's existing insurance coverage.

(4) The training and education program must be submitted for review and approval pursuant to 33-17-1204 and 33-17-1205.

History: **En. Sec. 3, Ch. 409, L. 2003.**

33-17-1504. Rental vehicle entity requirements. A rental vehicle entity may not solicit, negotiate, or sell rental vehicle insurance unless:

(1) at every location where rental vehicle agreements are executed, the rental vehicle entity prominently displays and makes readily available written material to each renter who may purchase rental vehicle insurance that:

(a) summarizes the material terms, exclusions, limitations, and conditions of coverage offered to renters, including the identity of the insurer;

(b) describes the process for filing claims in the event that the renter elects to purchase the coverage, including a toll-free telephone number to report a claim;

(c) provides the rental vehicle entity's name, address, telephone number, and business entity license number, as well as the commissioner's consumer hotline telephone number;

(d) informs the renter that the rental vehicle entity may provide a duplication of coverage already provided by a renter's automobile insurance policy;

(e) informs the renter that the purchase by the renter of the rental vehicle insurance is not required in order to rent a vehicle; and

(f) informs the renter that neither the rental vehicle entity nor the customer service representative is qualified to evaluate the adequacy of the renter's existing insurance coverage.

(2) Evidence of the rental vehicle insurance coverage must be stated in the rental agreement.

(3) The cost of the rental vehicle insurance must be separately itemized in the rental agreement, unless preselection of coverage is made in a master, corporate, or group agreement.

History: **En. Sec. 4, Ch. 409, L. 2003.**

33-17-1505. Recordkeeping and trust fund requirements. (1) A rental vehicle entity shall keep records of insurance transactions pursuant to 33-17-1101.

(2) The commissioner may not require a rental vehicle entity to hold rental vehicle insurance premium in a separate trust account pursuant to 33-17-1102 if the premium for rental vehicle insurance is itemized as part of the rental agreement.

History: **En. Sec. 5, Ch. 409, L. 2003.**

Part 16
Bail Bond Insurance License

Part Cross-References

Continuing education — basic requirements — exceptions, 33-17-1203.

33-17-1601. Special qualifications for surety bail bond insurance license. (1) Before approving an application for a surety bail bond insurance license, the commissioner shall verify that the individual:

(a) is a natural person at least 18 years of age;

(b) is a citizen of the United States or is lawfully entitled to remain and work in the United States;

(c) maintains a fixed place of business or is a full-time agent within the state;

(d) has obtained a high school diploma, a general equivalency diploma or equivalent document, or an equivalent education as determined by the commissioner;

(e) has complied with the requirements of 33-17-211; and

(f) has successfully completed the training required in 33-17-1602.

(2) An individual may not receive, renew, or hold a surety bail bond license if the individual:

(a) has been convicted of a felony in this state or of any offense committed in another state that would be a felony if committed in this state; or

(b) has been convicted of an offense involving dishonesty, a breach of trust, violence, threatened violence, or the unlawful use, sale, or possession of a controlled substance.

History: En. Sec. 1, Ch. 592, L. 2023; amd. Sec. 1, Ch. 473, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 1, Ch. 473, L. 2025. Amendment effective October 1, 2025.

33-17-1602. Surety bail bond insurance license — basic course of training — temporary license. (1) Except as otherwise provided in this section, an applicant for a surety bail bond insurance license shall satisfactorily complete a basic course of training for bail enforcement agents that is approved by the commissioner.

(2) Before approving an application for a surety bail bond insurance license, the commissioner shall verify that the individual:

(a) holds a high school diploma, general equivalency diploma, or equivalent; and

(b) has no felony convictions or offenses involving dishonesty, violence, or controlled substances.

(3) Applicants shall complete a 16-hour basic training course that includes instruction in:

(a) constitutional law and civil liability;

(b) rights of individuals in custody;

(c) use of force guidelines;

(d) procedures for arresting and surrendering defendants;

(e) handling individuals with mental health or substance use challenges;

(f) defensive tactics;

(g) bail bond ethics; and

(h) report writing and form completion.

(4) Once every 2 years, licensees shall complete continuing education that includes high-quality relevant instruction for:

(a) 1 hour on updates to state and federal laws affecting the bail industry; and

(b) 4 hours of approved credits on general bail industry knowledge or trends that is provided by a recognized state or national bail industry association or any other approved provider.

(5) (a) The commissioner may issue a temporary license valid for up to 12 months, allowing applicants to operate under supervision while completing training requirements. Supervision must be provided by a licensed surety bail bond agent who:

(i) has been licensed and actively in business in Montana for at least 5 consecutive years;

(ii) is a resident of the state; and

(iii) is in good standing with the commissioner of insurance, with no disciplinary actions or violations within the past 5 years.

(b) Renewal of the temporary license is prohibited to ensure timely completion of all training and licensing requirements.

(6) Existing licensed surety bail bond agents are exempt from initial training requirements but shall participate in the biennial continuing education program.

(7) (a) In lieu of completing the basic course of training required by subsection (1), an applicant may submit proof to the commissioner that the applicant has completed a course of training required by a municipal, state, or federal law enforcement agency or a branch of the armed forces to carry out the duties of a peace officer.

(b) Proof of on-the-job training in the basic course of training areas is sufficient for the commissioner to find that granting a surety bail bond insurance license is in the public interest. The commissioner's decision whether to grant or deny a waiver under this subsection (7) is not subject to the provisions provided in Title 33, chapter 1, part 7.

(8) An applicant for a surety bail bond insurance license shall complete the training required by this section within 12 months after the date the applicant is employed by a licensed surety bail bond agent. The commissioner may issue a temporary license to an applicant who has not completed the training if the applicant is otherwise qualified to be issued a license as a surety bail bond agent. The temporary license:

(a) authorizes the applicant to act as a surety bail bond agent while employed by a licensed surety bail bond agent;

(b) is valid for up to 12 months; and

(c) may not be renewed.

History: En. Sec. 2, Ch. 592, L. 2023; amd. Sec. 2, Ch. 473, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 2, Ch. 473, L. 2025. Amendment effective October 1, 2025.

CHAPTER 18
UNFAIR TRADE PRACTICES

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Chapter Cross-References

Unfair trade practices and consumer protection, Title 30, ch. 14.

Personal solicitation sales — exemption for insurance sales, 30-14-502.

Insurance contracts — policy requirements — construction, Title 33, ch. 15.

Part 1
General Provisions

33-18-101. Purposes. The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in Public Law 79-15 (the McCarran-Ferguson Act, 15 U.S.C. 1011 through 1015), which was approved March 9, 1945, by defining or providing for determination of all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

History: En. Sec. 203, Ch. 286, L. 1959; amd. Sec. 6, Ch. 320, L. 1977; R.C.M. 1947, 40-3501.

33-18-102. Unfair methods or deceptive practices prohibited — refusal to renew. (1) No person shall engage in this state in any trade practice which is defined in this chapter as or determined pursuant to this chapter to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

(2) Nothing in this chapter shall be construed to prevent an insurer owned or controlled by an association or organization, including a mutual insurer formed to provide insurance to the members of an association or organization, from refusing to renew a casualty or liability policy for nonpayment of dues to the association or organization if payment of dues is a condition for obtaining or continuing such insurance.

History: En. Sec. 204, Ch. 286, L. 1959; R.C.M. 1947, 40-3502; amd. Sec. 2, Ch. 319, L. 1981; amd. Sec. 1, Ch. 143, L. 1983.

33-18-103. Protection of active duty members of armed forces — rulemaking authority. (1) (a) As used in this section, "life insurance product" means any product, including individual and group life insurance, funding agreements, and annuities, that provides insurance for which the probabilities of the duration of human life or the rate of mortality are an element or condition of insurance.

(b) The term includes the granting of:

(i) endowment benefits;

(ii) additional benefits in the event of death by accident or accidental means;

(iii) disability income benefits;

(iv) additional disability benefits that operate to safeguard the contract from lapse or to provide a special surrender value or special benefit in the event of total and permanent disability;

(v) benefits that provide payment or reimbursement for long-term home health care or long-term care in a nursing home or other related facility;

(vi) burial insurance; and

(vii) optional modes of settlement or proceeds of life insurance.

(c) The term does not include workers' compensation insurance, health insurance, disability insurance, property and casualty insurance, or life insurance products specifically contracted by or through the federal government.

(2) As provided in Public Law 109-290, in cooperation with the national association of insurance commissioners, the commissioner shall:

(a) work collectively with other states to develop and implement appropriate standards to protect active duty members of the armed forces from dishonest and predatory insurance sales practices;

(b) identify this state's role in promoting standards developed pursuant to subsection (2)(a); and

(c) work collectively with other states to implement a system to receive and disseminate reports of disciplinary actions taken by federal or state government entities or insurers against persons that sell or solicit the sale of any life insurance product to active duty members of the armed forces.

(3) (a) The commissioner may adopt rules for:

(i) written disclosures to be used in the sale or solicitation of any life insurance product to active duty members of the armed forces and their dependents to protect the members or the members' dependents from dishonest and predatory insurance sales practices while located in this state;

(ii) requiring insurers to implement a system to report to the commissioner:

(A) disciplinary actions taken by a federal or state government entity with respect to sales or solicitations of life insurance products to active duty members of the armed forces that the insurer knows or in the exercise of due diligence should have known were taken; and

(B) significant disciplinary action taken by the insurer with respect to sales or solicitations of life insurance products to active duty members of the armed forces of this state.

(b) Rules adopted by the commissioner must be consistent with and may not go beyond the scope of:

(i) any model regulations that are adopted by the national association of insurance commissioners in response to a directive from the United States congress in Public Law 109-290, directing that the states ensure implementation of appropriate standards to protect active duty members of the armed forces from dishonest and predatory insurance sales practices;

(ii) rules or regulations adopted by the secretary of defense pursuant to Public Law 109-290; and

(iii) the requirements of Public Law 109-290.

History: En. Sec. 1, Ch. 333, L. 2007.

33-18-104. *(Effective January 1, 2026)* **Health insurance lead generators — scope and definitions.** For the purposes of 33-18-101, 33-18-102, 33-18-201 through 33-18-206, 33-18-208, 33-18-209, 33-18-302, 33-18-303, and Title 33, chapter 18, part 10, the following terms apply:

(1) "Health insurance lead generator" means a person who utilizes a lead-generating device to:

(a) publicize the availability of what is or what purports to be a health insurance product or service that the person is not licensed to sell directly to a customer;

(b) identify a customer who may want to learn more about a health insurance product; or

(c) sell or transmit customer information to insurers or producers for follow-up contact and sales activity.

(2) "Lead-generating device" means any communication directed to the public that, regardless of form, content, or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of the state for the purchase of what is or what purports to be a health insurance product or service.

(3) "Person" includes a health insurance lead generator.

History: En. Sec. 2, Ch. 229, L. 2025.

Compiler's Comments

Effective Date: Section 9, Ch. 229, L. 2025, provided: "[This act] is effective January 1, 2026."

Cross-References

Complaint handling — marketing — performance — record, 33-18-1001.

Part 2
Insurer's Relations With Insured and Claimant

33-18-201. Unfair claim settlement practices prohibited. A person may not, with such frequency as to indicate a general business practice, do any of the following:

(1) misrepresent pertinent facts or insurance policy provisions relating to coverages at issue;

(2) fail to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) refuse to pay claims without conducting a reasonable investigation based on all available information;

(5) fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) neglect to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempt to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempt to settle claims on the basis of an application that was altered without notice to or knowledge or consent of the insured;

(10) make claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made;

(11) make known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delay the investigation or payment of claims by requiring an insured, claimant, or physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) fail to promptly settle claims, if liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(14) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

(15) upon request of a policyholder or a producer designated by a policyholder, fail to provide a list of claims charged against a policy as required by 33-15-1126.

History: En. 40-3502.1 by Sec. 1, Ch. 320, L. 1977; R.C.M. 1947, 40-3502.1; amd. Sec. 1206, Ch. 56, L. 2009; amd. Sec. 3, Ch. 229, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 3, Ch. 229, L. 2025. Amendment effective January 1, 2026.

Cross-References

Punitive damages — when allowed, 27-1-220.

Insurance contracts — policy requirements — construction, Title 33, ch. 15.

Administrative penalty for failure to pay promptly — determination by Commissioner whether delay is general course of business practice, 33-18-232.

Crop hail insurance, Title 80, ch. 2, part 2.

33-18-202. Misrepresentation and false advertising of policies prohibited. A person may not make, issue, circulate, or cause to be made, issued, or circulated any estimate, illustration, circular, sales presentation, omission, comparison, or statement that:

(1) misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(2) misrepresents the dividends or share of the surplus to be received on any insurance policy;

(3) makes any false or misleading statement as to the dividends or share of surplus previously paid on any insurance policy;

(4) is misleading or is a misrepresentation as to the financial condition of any person or as to the legal reserve system upon which any life insurer operates;

(5) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature of the policy or class of policies;

(6) is a misrepresentation, including any intentional misquote of the premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(7) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy;

(8) misrepresents any insurance policy as being shares of stock; or

(9) offers or provides insurance as an inducement to the purchase of another policy or otherwise uses certain terms including but not limited to "free" or "no cost".

History: En. Sec. 205, Ch. 286, L. 1959; R.C.M. 1947, 40-3503; amd. Sec. 1, Ch. 9, L. 1979; amd. Sec. 4, Ch. 229, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 4, Ch. 229, L. 2025. Amendment effective January 1, 2026.

33-18-203. False or deceptive advertising prohibited. A person may not make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, electronic mail, internet advertisement or posting, or other publication or in the form of a notice, circular, pamphlet, letter, electronic posting of any kind, or poster, or over any radio or television station, or through the internet or other electronic means, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business that is untrue, deceptive, or misleading.

History: En. Sec. 206, Ch. 286, L. 1959; R.C.M. 1947, 40-3504; amd. Sec. 1207, Ch. 56, L. 2009; amd. Sec. 5, Ch. 229, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 5, Ch. 229, L. 2025. Amendment effective January 1, 2026.

Cross-References

Civil libel, 27-1-802.

Criminal defamation, 45-8-212.

33-18-204. Twisting prohibited. No person shall make or issue or cause to be made or issued any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing or attempting or tending to induce the policyholder to lapse, forfeit, surrender, retain, exchange, or convert any insurance policy.

History: En. Sec. 207, Ch. 286, L. 1959; R.C.M. 1947, 40-3505.

33-18-205. Filing or publishing false financial statements or making false entries prohibited. (1) No person shall file with any supervisory or other public official or make, publish, disseminate, circulate, or deliver to any person or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(2) No person shall make any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs or any public official to whom such insurer is required by law to report or who has authority by law to examine into its condition or into any of its affairs or, with like intent, willfully omit to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer. Any person who aids or abets in any such violation of this section shall be punishable upon conviction by a fine of $1,000 or by imprisonment in the county jail for 6 months or both such fine and imprisonment.

History: En. Sec. 208, Ch. 286, L. 1959; amd. Sec. 1, Ch. 29, L. 1967; R.C.M. 1947, 40-3506.

Cross-References

Unsworn falsification to authorities — misdemeanor, 45-7-203.

Misdemeanor — definition, 46-18-212.

33-18-206. Unfair discrimination prohibited — life insurance, annuities, and disability insurance. (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract.

(2) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder or in any of the terms or conditions of such contract or in any other manner whatever.

(3) An insurer may not refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay, or developmental disability.

(4) The rejection of an application or the determining of rates, terms, or conditions of a life or disability insurance contract on the basis of genetic condition, developmental delay,

or developmental disability constitutes unfair discrimination unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay, or developmental disability.

(5) As used in this section, the following definitions apply:

(a) "Developmental delay" means a delay of at least 1½ standard deviations from the norm.

(b) "Developmental disability" means the singular of developmental disabilities as defined in 53-20-202.

(c) "Genetic condition" means a specific chromosomal or single-gene genetic condition.

History: En. Sec. 211, Ch. 286, L. 1959; R.C.M. 1947, 40-3509; amd. Sec. 1, Ch. 318, L. 1991.

33-18-207. Preferred rates to fictitious groups prohibited — approval of preferred group rates and forms. (1) No insurer, whether an authorized insurer or an unauthorized insurer, shall make available through any rating plan or form, property, casualty, or surety insurance to any firm, corporation, or association of individuals, any preferred rate or premium based upon any fictitious group of such firm, corporation, or association of individuals.

(2) No form or plan of insurance covering any group or combination of persons or risks shall be written or delivered within or outside this state to cover persons or risks in this state at any preferred rate or on any form other than as offered to persons not in such group or combination and to the public generally unless such form, plan of insurance, and the rates or premiums to be charged therefor have been submitted to and approved by the commissioner as being not unfairly discriminatory and as not otherwise being in conflict with subsection (1) above or with any provision of parts 1 through 4 of chapter 16 to the extent that parts 1 through 4 are, by their terms, applicable thereto.

(3) This section does not apply to life insurance, disability insurance, workers' compensation insurance written for industry or business associations, or annuity contracts. However, workers' compensation group insurance rates are subject to all applicable provisions of chapter 16, part 10.

History: En. Sec. 222, Ch. 286, L. 1959; amd. Sec. 1, Ch. 292, L. 1977; R.C.M. 1947, 40-3520.

33-18-208. Contract to contain agreements — rebates prohibited — life, disability, and annuity contracts. Except as otherwise expressly provided by law and in 33-22-2204, a person may not knowingly:

(1) permit or offer to make or make any contract of life insurance, life annuity, or disability insurance or agreement as to such contract other than as plainly expressed in the contract issued thereon;

(2) pay or allow or give or offer to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity any rebate of premiums payable on the contract or any special favor or advantage in the dividends or other benefits thereon or any paid employment or contract for services of any kind or any valuable consideration or inducement whatever not specified in the contract;

(3) directly or indirectly give or sell or purchase or offer or agree to give, sell, purchase, or allow as inducement to such insurance or annuity or in connection therewith and whether or not to be specified in the policy or contract, any agreement of any form or nature promising returns and profits or any stocks, bonds, or other securities or interest present or contingent therein or as measured thereby of any insurance company or other corporation, association, or partnership or any dividends or profits accrued or to accrue thereon; or

(4) offer, promise, or give anything of value whatsoever not specified in the contract.

History: En. Sec. 212, Ch. 286, L. 1959; R.C.M. 1947, 40-3510; amd. Sec. 6, Ch. 600, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 6, Ch. 600, L. 2025. Amendment effective June 1, 2025.

Applicability: Section 9, Ch. 600, L. 2025, provided: "[This act] applies to dental insurance policies, plans, contracts, and certificates issued or renewed on or after January 1, 2026."

33-18-209. Exceptions to discrimination and rebates provision. Nothing in 33-18-206 and 33-18-208 shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer;

(2) in the case of life insurance policies issued on the industrial debit, preauthorized check, bank draft, or similar plans, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer or by preauthorized check, bank draft, or similar plans, in an amount which fairly represents the saving in collection expense;

(3) readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(4) reduction of premium rate for policies of large amount but not exceeding savings in issuance and administration expenses reasonably attributable to such policies as compared with policies of similar plan issued in smaller amounts;

(5) issuing life or disability insurance policies on a salary savings or payroll deduction plan at reduced rate reasonably commensurate with the savings made by the use of such plan.

History: **En. Sec. 213, Ch. 286, L. 1959; R.C.M. 1947, 40-3511.**

Cross-References

Discrimination in insurance and retirement plans, 49-2-309.

33-18-210. Unfair discrimination and rebates prohibited for title, property, casualty, or surety insurance — exceptions — limitations. (1) Except as provided in subsections (3), (4), and (11)(a), a title, property, casualty, or surety insurer or an employee, representative, or insurance producer of an insurer may not, as an inducement to purchase insurance or after insurance has been effected, pay, allow, or give or offer to pay, allow, or give, directly or indirectly, a:

(a) rebate, discount, abatement, credit, or reduction of the premium named in the insurance policy;

(b) special favor or advantage in the dividends or other benefits to accrue on the policy; or

(c) valuable consideration or inducement not specified in the policy, except to the extent provided for in an applicable filing with the commissioner as provided by law.

(2) Except as provided in subsections (3), (4), and (11)(a), an insured named in a policy or an employee of the insured may not knowingly receive or accept, directly or indirectly:

(a) a rebate, discount, abatement, credit, or reduction of premium;

(b) a special favor or advantage; or

(c) a valuable consideration or inducement.

(3) The prohibitions in subsections (1) and (2) do not apply to a benefit provided for by a telematics agreement as provided in 33-23-221 through 33-23-226 or a benefit or premium reduction for preventative measures taken by the insured for homeowner's insurance under 33-24-110.

(4) The prohibitions under subsections (1) and (2) do not apply to an active, retired, or honorably separated member of the United States armed forces as described in 33-18-217(1)(a) or to a spouse, surviving spouse, dependent, or heir of a United States armed forces member as provided in 33-18-217.

(5) An insurer may not make or permit unfair discrimination in the premium or rates charged for insurance, in the dividends or other benefits payable on insurance, or in any other terms and conditions of the insurance either between insureds or property having like insuring or risk characteristics or between insureds because of race, color, creed, religion, or national origin.

(6) This section may not be construed as prohibiting the payment of commissions or other compensation to licensed insurance producers or as prohibiting an insurer from allowing or returning lawful dividends, savings, or unabsorbed premium deposits to its participating policyholders, members, or subscribers.

(7) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew,

canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(8) An insurer may not make or permit unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained in the residential property because of the age of the residential property unless:

(a) the refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(b) the refusal, cancellation, or limitation is required by law or regulatory mandate.

(9) An insurer may not refuse to insure, refuse to continue to insure, or limit the amount of coverage available to an individual because of the sex or marital status of the individual. However, an insurer may take marital status into account for the purpose of defining persons eligible for dependents' benefits.

(10) An insurer may not terminate or modify coverage or refuse to issue or refuse to renew a property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subsection does not apply to accident and health insurance sold by a casualty insurer, and this subsection may not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract.

(11) (a) An insurer may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the amount of coverage available to an individual under a private passenger automobile policy based solely on adverse information contained in an individual's claims history and driving record that is 3 years old or older. An insurer may provide discounts to an insured under a private passenger automobile policy based on favorable aspects of an insured's claims history.

(b) An insurer may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the amount of coverage available under a commercial automobile policy based solely on adverse information contained in the loss experience or an insured's driving records that is 5 years old or older. An insurer may provide discounts to an insured under a commercial automobile policy based on favorable aspects of an insured's claims history.

(c) An insurer may not refuse to insure, refuse to continue to insure, charge higher rates, or limit the amount of coverage available under a personal homeowner policy based solely on adverse information contained in the loss experience that is 7 years old or older. An insurer may provide discounts to an insured under a personal homeowner policy based on favorable aspects of an insured's claims history.

(d) As used in subsection (11)(a), "private passenger automobile policy" means an automobile insurance policy issued to individuals or families but does not include policies known as commercial automobile policies.

(e) As used in subsection (11)(c), "personal homeowner policy" means property insurance under 33-1-210 that is sold by an insurer for personal, family, or household purposes.

(12) An insurer may not charge points or surcharge a private passenger motor vehicle policy because of a claim submitted under the insured's policy if the insured was not at fault.

(13) (a) An insurer that provides personal lines insurance for an insured may not consider the insured's inquiries or claims made to any insurer that did not result in a payment by any insurer in considering an application for, renewal of, or change in an insurance policy as defined in 33-15-102.

(b) This subsection (13) does not apply to an insurer's consideration of a claim that was the basis for a criminal or civil insurance fraud action by a state or regulatory enforcement entity.

(c) (i) For the purposes of this subsection (13), the term "personal lines insurance" means vehicle insurance under 33-1-206(1)(a) and property insurance under 33-1-210 that is sold by an insurer for personal, family, or household purposes.

(ii) The term does not include disability insurance or insurance for commercial, business, or professional services, products, or activities.

History: En. Sec. 214, Ch. 286, L. 1959; amd. Sec. 1, Ch. 191, L. 1969; amd. Sec. 5, Ch. 38, L. 1977; amd. Sec. 8, Ch. 320, L. 1977; R.C.M. 1947, 40-3512; amd. Sec. 19, Ch. 303, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 5, Ch. 699, L. 1991; amd. Sec. 35, Ch. 798, L. 1991; amd. Sec. 2, Ch. 320, L. 1995; amd. Sec. 1, Ch. 427, L. 1995; amd. Sec. 12, Ch. 363, L. 2005; amd. Sec. 2, Ch. 239, L. 2011; amd. Sec. 2, Ch. 98, L. 2015; amd. Sec. 7, Ch. 304, L. 2015; amd. Sec. 1, Ch. 178, L. 2017; amd. Sec. 2, Ch. 129, L. 2021; amd. Sec. 2, Ch. 174, L. 2021; amd. Sec. 4, Ch. 105, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 4, Ch. 105, L. 2025. Amendment effective October 1, 2025.

Cross-References

Discrimination in insurance and retirement plans, 49-2-309.

33-18-211. Stock operations and advisory board contracts. No person shall issue or deliver or permit its insurance producers, officers, or employees to issue or deliver agency company stock or other capital stock or benefit certificates or shares in any common-law corporation or any advisory board contract or other similar contract of any kind promising returns and profits as an inducement to insurance.

History: En. Sec. 215, Ch. 286, L. 1959; R.C.M. 1947, 40-3513; amd. Sec. 1, Ch. 713, L. 1989.

33-18-212. Illegal dealing in premiums — improper charges for insurance. (1) A person may not willfully collect any sum as a premium or charge for insurance that is not then provided or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as authorized by this code.

(2) A person may not willfully collect as a premium or charge for insurance any sum in excess of or less than the premium or charge applicable to the insurance and, as specified in the policy, in accordance with the applicable classifications and rates filed with or approved by the commissioner; or in cases in which classifications, premiums, or rates are not required by this code to be filed or approved, the premiums and charges may not be in excess of or less than those specified in the policy and as fixed by the insurer. This provision may not prohibit the charging and collection, by surplus lines insurance producers licensed under chapter 2, part 3, of the amount of applicable state and federal taxes in addition to the premium required by the insurer. This provision may not prohibit the charging and collection, by a life insurer, of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(3) This section does not prohibit the charging and collection of a flat fee by a surplus lines insurance producer as specified in 33-2-320 for transaction of surplus lines insurance policies.

History: En. Sec. 221, Ch. 286, L. 1959; R.C.M. 1947, 40-3519; amd. Sec. 1, Ch. 86, L. 1979; amd. Sec. 29, Ch. 537, L. 1987; amd. Sec. 41, Ch. 613, L. 1989; amd. Secs. 1, 2, Ch. 713, L. 1989; amd. Sec. 54, Ch. 379, L. 1995; amd. Sec. 3, Ch. 223, L. 2015; amd. Sec. 28, Ch. 396, L. 2017.

33-18-213. Extension of credit to policyholder. Notwithstanding any other provision of law, an insurance producer, as defined in 33-17-102, may extend credit to a policyholder in connection with the issuance or servicing of any policy procured or negotiated by the insurance producer, but any credit so extended must satisfy one of the following requirements:

(1) if credit is extended to a policyholder for not more than 30 days from the date the premium is due and the credit is not evidenced by a written instrument, no interest may be charged; or

(2) if credit is extended to a policyholder for more than 30 days from the date the premium is due and the credit is not evidenced by a written instrument, interest may be charged for credit extended after 30 days at a rate not more than 1½% a month on the unpaid balance; or

(3) if the extension of credit to a policyholder is evidenced by a written instrument signed by the policyholder, any interest charged for such credit shall be clearly stated in the instrument and may not exceed the legal rate of interest authorized in 31-1-107.

History: En. Sec. 1, Ch. 128, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-18-214. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 3, Ch. 357, L. 1995.

33-18-215. Postclaim underwriting prohibited — condition. An insurer, health service corporation, or health maintenance organization may not place an elimination rider on or rescind coverage provided by a disability policy, certificate, or subscriber contract after a policy, certificate, or contract has been issued unless the insured has made a material misrepresentation or fraudulent misstatement on the application or has failed to pay the premium when due.

History: **En. Sec. 1, Ch. 53, L. 1997.**

33-18-216. Unfair discrimination against victims of abuse prohibited. (1) An insurer, health maintenance organization, or health service corporation may not unfairly discriminate against a victim of abuse.

(2) For purposes of this section, "abuse" means the occurrence between family members, current or former household members, or intimate partners of one or more of the following:

(a) purposely, knowingly, or recklessly subjecting another person, including a minor child, to bodily injury, severe emotional distress, psychological trauma, sexual assault, or sexual intercourse without consent;

(b) subjecting another person, including a minor child, to false imprisonment or unlawful restraint or confinement.

(3) For purposes of this section, "abuse" includes purposely or knowingly engaging in a course of conduct toward a family member, current or former household member, or intimate partner that constitutes stalking in violation of 45-5-220.

(4) The following acts, when based on the insured's status as a victim of abuse, are prohibited as unfairly discriminatory:

(a) denying, refusing to issue, renew, or reissue, canceling, or otherwise terminating an insurance policy, certificate of coverage delivered or issued for delivery in Montana, subscriber contract, or health care services agreement;

(b) restricting or excluding coverage under an insurance policy or certificate delivered or issued for delivery in Montana;

(c) adding a premium differential to any insurance policy or certificate delivered or issued for delivery in Montana on the basis that the applicant or insured has been the victim of abuse; or

(d) excluding or limiting coverage for losses or denying a claim.

(5) Upon written request of the insured or an applicant, an insurer that takes an underwriting action that adversely affects a victim of abuse on the basis of a medical condition or property or casualty risk that the insurer knows is related to abuse shall explain to the insured or applicant in writing the reason for the insurer's action.

(6) (a) This section does not prohibit an insurer from underwriting, classifying risk, or administering a contract of insurance as otherwise allowed by law based on property or casualty risk or medical information that the insurer knows is related to abuse as long as the insurer underwrites, classifies risk, or administers the contract of insurance on the basis of the applicant's or insured's property or casualty risk or medical condition and not on the applicant's or insured's status as a victim of abuse.

(b) This section does not prohibit or otherwise limit an insurer's ability to elicit information from or about an applicant or insured as otherwise provided by law.

(7) This section may not be construed to alter or modify any conditions, exclusions, or limitations clearly stated in an insurance policy or certificate delivered or issued for delivery in Montana that are not otherwise inconsistent with the provisions of subsection (4).

(8) An insurer may not be held civilly or criminally liable for the death of or physical injury to an insured that is related to acts of abuse resulting from any action taken in a good faith effort to comply with the requirements of this section.

History: **En. Sec. 1, Ch. 304, L. 1997.**

33-18-217. Military discount exception to rebate and discount prohibition for property or casualty insurance. (1) The prohibition against rebates or discounts provided for in 33-18-210 does not apply with respect to property or casualty insurance sales to:

(a) an active, retired, or honorably separated member of the United States armed forces, including a member of a reserve component as defined in 37-1-138; or

(b) a spouse, surviving spouse, dependent, or heir of a United States armed forces member referred to in subsection (1)(a).

(2) This section does not permit unfair discrimination based on rank or pay grade.

History: **En. Sec. 1, Ch. 98, L. 2015.**

33-18-218. Insurer costs prohibited — duty to defend — exception. (1) Except as provided in 33-18-219 and subsection (2) of this section, an insurer may not recover costs of defending an insured against claims asserted against the insured if the insurer is subsequently determined to not owe a duty to defend the insured.

(2) An insurer may recover costs of defending an insured against claims asserted against the insured when the insurer is subsequently determined to not owe a duty to defend the insured if:

(a) the insurance policy or contract contains language giving the insurer the right to seek reimbursement or recover those costs from the insured;

(b) the insurer provides written notice to the insured that the insurer may seek reimbursement or recovery of those costs from the insured at the time the insurer assumes the defense of the claim or when an insurer discovers facts that lead the insurer to question whether a claim is covered, whichever is later; and

(c) the insurer institutes an action to determine whether the insurer owes the insured a duty to defend within 120 days of determining whether a question exists as to whether a claim is covered under the policy.

(3) The insured has the right to recover, or seek reimbursement of, those costs from a third party pursuant to a contract or agreement or as otherwise provided by law, but only to the extent an insurer has recovered those costs.

(4) Nothing in this section compromises an insurer's right to seek recovery or reimbursement of costs under this section from any party other than the insured against whom the claim has been asserted.

History: En. Sec. 1, Ch. 419, L. 2023.

33-18-219. Exceptions to applicability. Section 33-18-218 does not apply and an insurer may seek reimbursement from an insured for any amount paid by the insurer in defending any claim asserted against an insured if:

(1) the insured made fraudulent or material misrepresentations or concealed or omitted facts or information in the application for insurance, and the insurer, in good faith, would not have issued the policy or contract if the true facts had been made known to the insurer;

(2) the insured made fraudulent or material misrepresentations or concealed or omitted facts or information in the submission of the claim; or

(3) the insurance policy or contract is a professional liability insurance policy or contract.

History: En. Sec. 2, Ch. 419, L. 2023.

33-18-220 reserved.

33-18-221. Designation of specific repair shops prohibited — lists allowed. (1) An insurance company, including its producers and adjusters, that issues or renews a policy of insurance in this state covering, in whole or part, a motor vehicle may not:

(a) require that a person insured under the policy use a particular company or location for providing automobile glass replacement, glass repair services, or glass products insured in whole or part by the policy; or

(b) engage in any act or practice of intimidation, coercion, or threat for or against an insured person to use a particular company or location to provide automobile glass replacement, glass repair services, or glass products insured, in whole or in part, under the terms of an insurance policy.

(2) (a) An insurance company may provide an insured with a list that includes the names of particular companies or locations providing automobile glass replacement, glass repair services, or glass products if some of the listed companies or locations are reasonably close and convenient to the insured. The insurance company may restrict the list to those companies or locations that meet reasonable standards of quality, service, and safety.

(b) The insured may use a nonlisted company or location at the insured's sole discretion, and subject to the provisions of subsections (2)(c) and (3), the insurance company will fully and promptly pay for the cost of automobile glass replacement, glass repair services, or glass products provided, less any deductible under the terms of the policy.

(c) If the insured does not use a list as provided in subsection (2)(a), the insurer may require the insured to obtain not more than three competitive bids to establish the cost of automobile glass replacement, glass repair services, or glass products provided.

(3) This section does not require an insurer to pay more for automobile glass replacement, glass repair services, or glass products than the market price as defined in 33-18-222.

(4) Notwithstanding the provisions of subsections (1) through (3), an insurance company may agree to pay the full cost of glass replacement or repair.

History: En. Sec. 1, Ch. 554, L. 1993; amd. Sec. 2, Ch. 526, L. 1999; amd. Sec. 2, Ch. 345, L. 2001; amd. Sec. 1, Ch. 192, L. 2009.

33-18-222. Market price. (1) For purposes of 33-18-221, 33-18-223, and 33-18-224, "market price" means the:

(a) price agreed upon between the insurer and the business; or

(b) prevailing competitive rate that is reasonable and necessary in the local area where the repairs are to be performed.

(2) The market price may not be less than cost as provided in 30-14-209.

History: En. Sec. 2, Ch. 554, L. 1993; amd. Sec. 3, Ch. 526, L. 1999; amd. Sec. 3, Ch. 345, L. 2001; amd. Sec. 2, Ch. 192, L. 2009.

33-18-223. Prohibited activities — glass broker defined. (1) It is unlawful for an insurance company, individually or with others, to directly or indirectly:

(a) establish an agreement with any person to act as a glass broker for the insurance company under which the glass broker sets a price that must be met by a glass repair shop as a condition for doing glass replacement or glass repair work for the insurance company;

(b) establish an agreement with a glass broker that requires a glass repair shop to bill through that glass broker as a condition of doing glass replacement or glass repair work; or

(c) establish a price that must be met by a glass repair shop as a condition for doing glass replacement or glass repair work that is below the market price as provided in 33-18-222.

(2) As used in this section, "glass broker" means an automobile glass company that acts as a third-party agent for the insurer whenever the glass broker enters into agreements with other automobile glass dealers to perform glass replacement or glass repair work.

History: En. Sec. 3, Ch. 554, L. 1993; amd. Sec. 2, Ch. 207, L. 1997; amd. Sec. 4, Ch. 526, L. 1999; amd. Sec. 4, Ch. 345, L. 2001; amd. Sec. 3, Ch. 192, L. 2009.

Cross-References

Automobile glass — sale, repair, or replacement — advertising allowed, 30-14-225.

Windshield tinting — restrictions, 61-9-405.

33-18-224. Designation of specific automobile body repair businesses prohibited. (1) (a) An insurance company, including its producers and adjusters, that issues or renews a policy of insurance in this state covering, in whole or in part, a motor vehicle may not:

(i) require that a claimant under the policy use a particular automobile body repair business or location for an estimate or a repair;

(ii) engage in any act or practice that intimidates, coerces, or threatens a claimant or that provides an incentive or inducement for a claimant to use a particular automobile body repair business or location; or

(iii) unilaterally disregard a repair operation or cost identified by an estimating system that the insurer and an automobile body repair business or location have agreed to utilize in determining the cost of repair.

(b) An insurance company, including its producers and adjusters, that issues or renews a policy of insurance in this state covering, in whole or in part, a motor vehicle may have access to the motor vehicle for purposes of preparing a competitive estimate.

(2) (a) Except as provided in subsection (2)(b), if an insurance company has direct repair programs with automobile body repair businesses or locations, the insurance company may not limit the number of automobile body repair businesses or locations with whom it maintains direct repair programs.

(b) An insurance company may limit the number of automobile body repair businesses or locations participating in the insurance company's direct repair program to those automobile body repair businesses or locations that comply with the provisions of subsection (2)(c).

An insurance company is not required to establish a direct repair program in a particular market area in which the insurance company's number of policyholders does not support establishing a direct repair program with any automobile body repair business or location.

(c) Upon request, the insurance company shall provide, without prejudice or bias, the claimant with a list that includes all automobile body repair businesses or locations that are reasonably close or convenient to the claimant and willing to provide services and that meet the insurance company's criteria regarding whether the automobile body repair business or location:

(i) possesses the equipment necessary to undertake repairs;

(ii) undertakes training of management and technical personnel with respect to repair information and the claims process;

(iii) agrees to perform quality repairs at the market price and that meet reasonable industry repair standards;

(iv) agrees to warrant the quality of work, including refinishing, in writing to the claimant, for a period of not less than 1 year from the date of repair;

(v) agrees to inspection of its repairs and services by the insurance company and agrees that the insurance company may terminate the direct repair program with the automobile body repair business or location if the repairs and services are below the standards of quality required by the insurance company; and

(vi) if requested, agrees to execute an agreement with the insurance company that may contain additional criteria that are not designed to unfairly limit the number of automobile body repair businesses or locations with whom the insurance company maintains direct repair programs. The additional criteria may include criteria determined to be necessary by the insurance company and designed to ensure that the automobile body repair business or location has the necessary estimating systems and programs and equipment to communicate electronically with the insurance company and that the automobile body repair business or location has taken steps to ensure the privacy of the insurance company and the claimant.

(d) If the claimant requests the list provided for in subsection (2)(c), the insurance company shall inform the claimant that the claimant may use an automobile body repair business or location at the sole discretion of the claimant.

(3) For the purposes of this section, an incentive or inducement does not include:

(a) providing a claimant with the list provided for in subsection (2)(c); or

(b) referring to a warranty issued by an automobile body repair business or location.

(4) The claimant may use an automobile body repair business or location at the claimant's sole discretion, and the insurance company shall pay for the reasonable and necessary cost of the automobile body repair services for covered damages, less any deductible under the terms of the policy. This section does not require an insurer to pay more for automobile body repair services than the market price, as defined in 33-18-222.

(5) If the claimant uses an automobile body repair business or location that is not on a list provided for in subsection (2)(c), the insurance company may not be held liable for any repair work performed by the automobile body repair business or location chosen by the claimant.

(6) It is unlawful for an automobile body repair business or location to charge or agree to charge a claimant more than an uninsured customer for any automobile body repair service.

(7) An insurance company that contracts with an independent adjuster may not be held liable for the independent adjuster's failure to comply with the terms of this section.

(8) For purposes of this section:

(a) "automobile body repair business or location" does not include a business or location that exclusively provides automobile glass replacement, glass repair services, or glass products;

(b) "claimant" means the person seeking repair of a motor vehicle whether that person is the insured person or a third party making a claim against the insurer.

History: En. Sec. 1, Ch. 292, L. 1997; amd. Sec. 5, Ch. 526, L. 1999; amd. Sec. 5, Ch. 345, L. 2001; amd. Sec. 1, Ch. 407, L. 2005; amd. Sec. 1, Ch. 339, L. 2007; amd. Sec. 4, Ch. 192, L. 2009; amd. Sec. 1, Ch. 290, L. 2011.

Cross-References

Montana Professional Tow Truck Act, Title 61, ch. 8, part 9.

State law enforcement rotation system — local government rotation system, 61-8-908.

33-18-225. Designation of specific car rental business prohibited. (1) An insurance company, including its producers and adjusters, that issues or renews a policy of insurance in this state covering, in whole or in part, a motor vehicle may not:

(a) require that a person, whether or not insured by the insurance company, for whom the insurance company is obligated to provide a car rental while the person's own car is being repaired use a particular car rental business; or

(b) engage in any act or practice that intimidates, coerces, or threatens a person to use a particular car rental business.

(2) (a) An insurance company that is subject to the provisions of this section and that provides for direct payment to any one or more car rental businesses in this state must provide for direct payment to any car rental business selected by a person described in subsection (1)(a).

(b) For the purposes of this section, "direct payment" means a method by which an insurance company makes a direct payment on behalf of an insured or a third party either through electronic means or by check to a car rental business.

(c) The insurance company may approve the daily rate to be paid by the insurance company based on the car classification.

(d) The insurance company is not obligated to pay more to the car rental business than is provided in the insured's policy limits pursuant to 33-23-203.

(3) This section does not require an insurer to pay more for a comparable car rental than the lowest price negotiated between a car rental business and the insurer.

(4) This section does not prohibit an insurer, its producers, or its adjusters from providing to a customer the name of a car rental business with which arrangements may have been made to provide car rental services as long as the ultimate choice is left to the person described in subsection (1)(a).

History: **En. Sec. 1, Ch. 251, L. 2005.**

33-18-226 through 33-18-230 reserved.

33-18-231. State administrative process to provide timely payment of medical benefits — definitions. In 33-18-231 through 33-18-235 the following definitions apply:

(1) "Claim documentation" means standard claims forms or other documentation routinely accepted by insurers as proof of loss.

(2) "Insurer" means any insurer as that term is defined by this title, including any fraternal benefit society, hospital service nonprofit corporation, health service corporation, nonprofit medical service corporation, nonprofit health care corporation, health maintenance organization, self-insurer, or third-party administrator or any other public or private, profit or nonprofit, governmental or nongovernmental individual, group, or organization that sells or offers for sale insurance policies, subscriber contracts, certificates, or agreements by which the offerer promises to pay medical benefits in any form in this state.

(3) "Proof of loss" means any claim documentation received by an insurer upon which payment of claims is requested.

History: **En. Sec. 1, Ch. 300, L. 1983; amd. Sec. 1, Ch. 378, L. 2003.**

33-18-232. Time for payment of claims. (1) An insurer shall pay or deny a claim within 30 days after receipt of a proof of loss unless the insurer makes a reasonable request for additional information or documents in order to evaluate the claim. If an insurer makes a reasonable request for additional information or documents, the insurer shall pay or deny the claim within 60 days of receiving the proof of loss unless the insurer has notified the insured, the insured's assignee, or the claimant of the reasons for failure to pay the claim in full or unless the insurer has a reasonable belief that insurance fraud has been committed and the insurer has reported the possible insurance fraud to the commissioner. This section does not eliminate an insurer's right to conduct a thorough investigation of all the facts necessary to determine payment of a claim.

(2) If an insurer fails to comply with this section and the insurer is liable for payment of the claim, the insurer shall pay an amount equal to the amount of the claim due plus 10% annual interest calculated from the date on which the claim was due. For purposes of calculating the amount of interest, a claim is considered due 30 days after the insurer's receipt of the proof of loss or 60 days after receipt of the proof of loss if the insurer made a reasonable request for

information or documents. Interest payments must be made to the person who receives the claims payment. Interest is payable under this subsection only if the amount of interest due on a claim exceeds $5.

(3) A private cause of action under 33-18-201 or 33-18-242 may not be based on the compliance or noncompliance with the requirements of this section and evidence of compliance or noncompliance with this section is not admissible in any private action based on 33-18-201 or 33-18-242.

History: **En. Sec. 2, Ch. 300, L. 1983; amd. Sec. 2, Ch. 378, L. 2003; amd. Sec. 21, Ch. 469, L. 2005.**

Cross-References

Unfair claim settlement practices — unreasonable refusal to pay claims, 33-18-201.

33-18-233. Administrative penalty for failure to pay promptly. (1) The commissioner may, after a hearing, impose an administrative fine as provided in 33-1-317 on an insurer if the commissioner finds that the insurer as a general course of business practice in this state fails to:

(a) use due diligence in processing all claims;

(b) pay claims in a timely manner;

(c) provide proper notice, when required, with respect to the reasons for the insurer's failure to make claim payments when due;

(d) pay, without just cause, proper claims arising under coverage provided by its policies, whether the claims are in favor of an insured, in favor of a third person with respect to the liability of an insured to the third person, or in favor of any other person entitled to the benefits of a policy; or

(e) pay interest pursuant to 33-18-232(2).

(2) If an insurer can demonstrate that it has consistently paid 90% of the total dollar amount outstanding in claims to each claimant within 20 working days and all of the amount within 30 working days of receipt of claims during the 6-month period immediately preceding the hearing date, the insurer is not subject to the fine described in subsection (1).

History: **En. Sec. 3, Ch. 300, L. 1983; amd. Sec. 3, Ch. 378, L. 2003.**

Cross-References

Unfair claim settlement practices — unreasonable refusal to pay claims, 33-18-201.

33-18-234. Right of privacy guaranteed. Nothing in 33-18-231 through 33-18-235 requires the commissioner to disclose information in violation of the Insurance Information and Privacy Protection Act.

History: **En. Sec. 4, Ch. 300, L. 1983.**

Cross-References

Insurance information and privacy protection, Title 33, ch. 19.

33-18-235. Rulemaking authority. The commissioner may adopt rules, under the Montana Administrative Procedure Act, necessary to implement 33-18-231 through 33-18-234.

History: **En. Sec. 5, Ch. 300, L. 1983; amd. Sec. 9, Ch. 399, L. 2007.**

Cross-References

Montana Administrative Procedure Act, Title 2, ch. 4.

33-18-236 through 33-18-240 reserved.

33-18-241. Repealed. Sec. 2, Ch. 278, L. 1987.

History: **En. Sec. 1, Ch. 504, L. 1985.**

33-18-242. Independent cause of action — burden of proof. (1) An insured or a third-party claimant has an independent cause of action against an insurer for actual damages caused by the insurer's violation of 33-18-201(1), (4), (5), (6), (9), or (13).

(2) In an action under this section, a plaintiff is not required to prove that the violations were of such frequency as to indicate a general business practice.

(3) An insured who has suffered damages as a result of the handling of an insurance claim may bring an action against the insurer for breach of the insurance contract, for fraud, or pursuant to this section, but not under any other theory or cause of action. An insured may not bring an action for bad faith in connection with the handling of an insurance claim.

(4) A third-party claimant who has suffered damages as a result of the handling of an insurance claim may bring an action against the insurer for fraud or pursuant to this section,

but not under any other theory or cause of action. A third-party claimant may not bring an action for bad faith in connection with the handling of an insurance claim.

(5) In an action under this section, the court or jury may award such damages as were proximately caused by the violation of 33-18-201(1), (4), (5), (6), (9), or (13). Exemplary damages may also be assessed in accordance with 27-1-221.

(6) An insurer may not be held liable under this section if the insurer had a reasonable basis in law or in fact for contesting the claim or the amount of the claim, whichever is in issue.

(7) (a) An insured may file an action under this section, together with any other cause of action the insured has against the insurer. Actions may be bifurcated for trial where justice so requires.

(b) A third-party claimant may not file an action under this section until after the underlying claim has been settled or a judgment entered in favor of the claimant on the underlying claim.

(8) The period prescribed for commencement of an action under this section is:

(a) for an insured, within 2 years from the date of the violation of 33-18-201; and

(b) for a third-party claimant, within 1 year from the date of the settlement of or the entry of judgment on the underlying claim.

(9) As used in this section, the term "insurer" does not include a person, firm, or corporation utilizing a captive insurance company to pay claims made against it, unless that captive insurance group is a captive risk retention group.

History: En. Sec. 3, Ch. 278, L. 1987; amd. Sec. 1, Ch. 356, L. 2023; amd. Sec. 2, Ch. 430, L. 2023.

33-18-243. Insured and third-party claimant's duties — affirmative defense. (1) An insured or a third-party claimant shall cooperate with an insurer with respect to an insurance claim or cause of action made or asserted against the insured, the insurer, or both, or reported to the insurer. The duty to cooperate includes, in addition to other duties specified in the insurance policy, the duty to comply with the reasonable requests of the insurer in the investigation and handling of the insurance claim.

(2) An insured or a third-party claimant shall deliver claim information to the insurer to allow the insurer a fair and reasonable opportunity to investigate and evaluate each claim made against an insured, insurer, or both, or reported to the insurer.

(3) A breach of any of the duties of an insured or a third-party claimant set forth in this section does not create a separate or independent cause of action by an insurer against an insured or a third-party claimant, but the breach of a duty may be:

(a) considered as evidence regarding whether the insurer had an opportunity to conduct a reasonable investigation based on the reasonably available claim information and whether the insurer had a reasonable basis in law or in fact for contesting the claim or the amount of the claim; and

(b) asserted by an insurer as an affirmative defense to a cause of action commenced by an insured or a third-party claimant under 33-18-242 for an insurer's alleged violation of 33-18-201(4), (5), or (6), or commenced by an insured or a third-party claimant that alleges the insurer's breach of contract or the insurer's breach of the implied covenant of good faith and fair dealing.

(4) An insurer may introduce any evidence in a civil action regarding the actions, inactions, and other conduct of an insured or a third-party claimant in a civil action commenced by an insured or a third-party claimant with respect to a claim or cause of action under 33-18-242 for an insurer's alleged violation of 33-18-201(4), (5), or (6), or commenced by an insured or a third-party claimant that alleges the insurer's breach of contract or the insurer's breach of the implied covenant of good faith and fair dealing.

(5) For the purposes of this section, the following definitions apply:

(a) (i) "Claim information" means documents, records, or information created, maintained, or stored in a media format that is reasonably available to an insured or a third-party claimant and that relates to, establishes, proves, or may tend to establish or prove:

(A) damages of any kind or nature relating to the claim or cause of action against the insured, insurer, or both; and

(B) the liability of the insured, insurer, or both to pay, satisfy, or otherwise compensate for the damages as provided in subsection (5)(a)(i)(A).

(ii) The term includes information that is reasonably available to an insured or a third-party claimant only if the claim information is in the possession of the insured or third-party claimant, or their representatives or attorneys, or if the claim information can be reasonably obtained by the insured or third-party claimant on request.

(b) "Insured" means an individual or entity insured under an insurance policy, against whom a third-party claimant is making, alleging, or pursuing an insurance claim or cause of action for damages, or an individual or entity making, alleging, or pursuing a claim or cause of action for which coverage may be provided by the insurance policy issued by the insurer to the individual or entity.

(c) "Third-party claimant" means a third party making, alleging, or pursuing an insurance claim or cause of action against an insured for damages, or against an insurer pursuant to 33-18-242. For purposes of this definition, the term also means an attorney or any other authorized representative acting for or on behalf of the third-party claimant or any assignee of the third-party claimant.

History: En. Sec. 1, Ch. 430, L. 2023.

33-18-244 reserved.

33-18-245. Prompt payment of motor vehicle damage claims. (1) Except for providers who are prepaid or agree to a different payment schedule, an insurer shall make an offer to pay or shall pay all approved claims for covered services or damages that solely involve the recovery of property damages in an amount of $2,500 or less arising out of the ownership, maintenance, or use of a motor vehicle within 30 working days of receipt of a proof of loss that is correctly completed and submitted to the insurer.

(2) Subsection (1) does not apply to an insurer who has notified the insured or the insured's assignee of the reasons for the insurer's failure to pay the claim in full or to an insurer that has made a reasonable request for additional information or documents.

History: En. Sec. 4, Ch. 378, L. 2003.

33-18-246 reserved.

33-18-247. Unfair discrimination prohibited — anatomical gifts, organ transplants, and related treatment. (1) An insurer that provides coverage for anatomical gifts, organ transplants, or related treatment and services may not:

(a) deny coverage under an insurance policy to a covered person solely on the basis of the person's disability;

(b) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under an insurance policy, solely for the purpose of avoiding the requirements of this section;

(c) penalize or otherwise reduce or limit the reimbursement of an attending provider or provide monetary or nonmonetary incentives to an attending provider to induce the provider to provide care to an insured or enrollee in a manner inconsistent with this section; or

(d) reduce or limit coverage benefits to a patient for the medical services or other services related to organ transplantation performed pursuant to this section as determined in consultation with the attending physician and patient.

(2) In the case of an insurance policy maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers, any plan amendment made pursuant to a collective bargaining agreement that amends the plan solely to conform to a requirement imposed pursuant to this section may not be treated as a termination of the collective bargaining agreement.

(3) Nothing in this section may be construed to require a health insurance issuer to provide coverage for a medically inappropriate organ transplant.

History: En. Sec. 5, Ch. 487, L. 2021.

33-18-248 and 33-18-249 reserved.

33-18-250. *(Effective January 1, 2026)* **Unfair financial planning practices — producers.** (1) (a) An insurance producer may not directly or indirectly hold the insurance producer out to the public as a financial planner, investment adviser, consultant, financial counselor, or any other type of specialist engaged in the business of providing financial planning or advice relating to investments, insurance, real estate, tax matters, or trust and estate matters if the insurance producer:

(i) is engaged in only the sale of insurance policies; and

(ii) does not hold a formal and recognized financial planning or consultant certification or designation.

(b) Subsection (1)(a) does not preclude an insurance producer who holds a formal and recognized financial planning or consultant certification or designation from displaying the certification or designation when only selling insurance. An insurance producer who is selling insurance as provided in this subsection (1)(b) may not charge an additional fee for services that are customarily associated with the solicitation, negotiation, or servicing of policies.

(2) (a) An insurance producer may not engage in the business of financial planning without disclosing to the client prior to the execution of the agreement that:

(i) the insurance producer is also an insurance producer; and

(ii) a commission for the sale of an insurance product will be received by the insurance producer in addition to the fee for financial planning.

(b) The disclosure requirement under subsection (2)(a) may be met by including the required information in any disclosure required by federal or state securities law.

(3) (a) An insurance producer may not charge fees for financial planning unless the fees are based on a written agreement signed by the party to be charged before the services under the agreement are performed.

(b) A copy of the agreement must be provided to the party to be charged at the time the agreement is signed by the party. The written agreement must specifically state:

(i) the services for which the fee is to be charged;

(ii) the amount of the fee to be charged or how it will be determined or calculated; and

(iii) that the client is under no obligation to purchase an insurance product through the insurance producer or consultant.

(c) The insurance producer shall retain a copy of the agreement for not less than 3 years after completion of services, and a copy must be available to the commissioner on request.

History: **En. Sec. 1, Ch. 229, L. 2025.**

Compiler's Comments

Effective Date: Section 9, Ch. 229, L. 2025, provided: "[This act] is effective January 1, 2026."

33-18-251. Time-limited demands — requirements — insurer's fair and reasonable opportunity to investigate and evaluate claims. (1) A time-limited demand from a claimant to an insurer offering to settle any claim must:

(a) reference this section;

(b) be in writing and labeled "time sensitive" at the top of the first page of the writing setting forth the required material terms of the offer to settle set forth in subsection (1)(d);

(c) be sent certified mail, return-receipt requested, to the insurer of the allegedly responsible party; and

(d) contain the following material terms:

(i) the name of the allegedly responsible party;

(ii) the time period within which the offer to settle shall remain open for acceptance by the allegedly responsible party's insurer, which may not be less than 60 days or the first business day following the 60th day when that day falls on a weekend or holiday;

(iii) the amount of the monetary payment requested to settle the claim, together with a description of any other form of consideration sought to settle the claim;

(iv) the date and location of the damage, loss, professional negligence, or breach of fiduciary duty;

(v) a reasonable description of the nature and extent of all known injuries, damages, and losses sustained by the claimant;

(vi) the party or parties to be released if the insurer accepts the time-limited demand;

(vii) a description of the claim or claims to be released if the time-limited demand is accepted; and

(viii) disclosure of eligibility, or information sufficient to verify eligibility, for medicare, medicaid, any other federal or state benefit program, and any other known liens or assignments granted by the claimant that apply to any of the damages claimed.

(2) The time period within which an insurer may accept a time-limited demand commences on the date the insurer actually receives the time-limited demand through certified mail.

(3) (a) A time-limited demand made pursuant to this section must be accompanied and supported by the following:

(i) all available and supporting documents, records, and information sufficient to allow the insurer a fair and reasonable opportunity to investigate and evaluate the nature and extent of the alleged responsible party's liability and the nature and extent of the claimant's injuries, damages, and losses;

(ii) medical records, invoices, and billing statements from all health care providers, if any, who provided treatment to or evaluated the claimant or decedent for:

(A) injuries suffered in connection with the claim from the date of injury until the date of the time-limited demand, including but not limited to emotional distress; and

(B) injuries, damages, losses, ailments, diseases, or other medical conditions occurring or existing prior to the date of injury that relate or may relate in any manner to any of the claimant's claims that are the subject of the written time-limited demand.

(b) If the claimant asserts a claim for loss of wages, earnings, compensation, or profits, however denominated, the claimant shall provide records from employers or other relevant sources or tax records to document the claimed loss.

(4) On receipt of a time-limited demand, the insurer has the right to provide a proposed settlement agreement or release, or both, or seek clarification or additional information regarding terms, liens, subrogation claims, alleged damages, standing to release claims, medical bills, medical records, preexisting medical conditions, and other relevant facts. The claimant has the duty to provide any missing or needed documents, records, and information reasonably requested by the insurer. A request for clarification or for additional documents, records, or information, or to propose a settlement agreement or release, or both, may not be deemed a counteroffer or rejection of the time-limited demand to settle. On a request or proposal, any time limit imposed within the time-limited demand is extended a minimum of either 30 days, or by the number of days from and including the date of the request to the date of receipt of the information responding to the requestor, whether the terms of a settlement agreement, a release, or both, are accepted or rejected.

(5) If, during the time period within which a time-limited demand may be accepted, it is determined that a lien attaches to any settlement payment to be paid by the allegedly responsible party's insurer, including but not limited to any actual or potential medicare or medicaid lien, the claimant has a duty to cooperate with the insurer to ensure satisfaction of any valid lien interest medicare, medicaid, or other lienholder may have in the settlement payment. In addition, any time limit imposed within the time-limited demand must be stayed from date the valid lien is identified until the date on which the claimant, allegedly responsible party, and the insurer agree to address and resolve satisfaction of the valid lien.

(6) If an insurer with the right to settle on behalf of an insured receives a time-limited demand, the insurer may accept the time-limited demand by providing written acceptance of the material terms outlined in subsection (1) that is delivered or postmarked to the claimant within the time period set in the time-limited demand. The person or entity providing payment to satisfy the material terms may elect to provide payment by any one or more of the following means:

(a) cash;

(b) money order;

(c) wire transfer;

(d) a cashier's check issued by a bank or other financial institution;

(e) a draft or bank check issued by an insurer; or

(f) electronic funds transfer or other method of electronic payment.

(7) In any civil action commenced by or on behalf of a claimant, or by a claimant as an assignee of the allegedly responsible party, or by the allegedly responsible party for the benefit of the claimant:

(a) a time-limited demand that does not strictly comply with the terms of this section may not be considered as a reasonable opportunity to settle for the insurer and may not be admissible in any civil action alleging extracontractual damages against the allegedly responsible party's liability insurer; and

(b) an insurer is not liable for any extracontractual damages arising from or related to any injuries, damages, or losses suffered by a claimant that are not identified in the time-limited demand and supported by the documents, records, and information set forth in subsection (3).

(8) If an insurer receives a time-limited demand from a claimant that the insurer knows or reasonably believes is not represented by an attorney, and the insurer determines that the time-limited demand does not strictly comply with the requirements set forth in subsections (1) and (3), the insurer is obligated to notify the claimant of the requirements within 10 business days of receiving the time-limited demand from the claimant. On delivery of the notice to the claimant, any time limit imposed within the time-limited demand is extended a minimum of either 30 days, or by the number of days from and including the date on which the claimant presents a time-limited demand to the insurer that strictly complies with the requirements in subsections (4) and (5). If an insurer becomes obligated under this section to notify a claimant and fails to deliver the notice to the claimant, subsection (7) may not apply in any civil action alleging extracontractual damages against the insurer.

(9) For purposes of this section, the following definitions apply:

(a) "Allegedly responsible party" means any person or entity:

(i) claimed or alleged to have caused or contributed to cause property damage, personal injury, bodily injury, wrongful death, professional negligence or liability, or breach of any fiduciary duty; or

(ii) claimed or alleged to have committed, engaged in, or be liable for professional negligence or breach of fiduciary duty.

(b) "Claimant" means:

(i) any injured party delivering a time-limited demand to an insurer, including but not necessarily limited to the injured party's attorney or any other authorized representative acting for or on behalf of the injured party;

(ii) any insured under an insurance policy pursuing a claim or cause of action arising from or related in any manner to the insurance policy issued by the insurer and delivering a time-limited demand to the insurer, including but not necessarily limited to the insured's attorney or any other authorized representative acting for or on behalf of the insured; or

(iii) any assignee of an injured party or insured delivering a time-limited demand to the insurer, including but not necessarily limited to the assignee's attorney or any other authorized representative acting for or on behalf of the assignee.

(c) "Extracontractual damages" means any amount of damages caused by the allegedly responsible party that exceeds the total available policy limit of liability for all policies of liability insurance that an insurer has issued to an allegedly responsible party and which policies of liability insurance are applicable to a claim for property damage, personal injury, bodily injury, wrongful death, professional negligence or liability, or breach of any fiduciary duty.

(d) "Insurer" means any insurer referred to or defined under 33-1-201 who has issued an insurance contract to an allegedly responsible party.

(e) "Time-limited demand" means any offer to settle any claim for personal injury, property damage, bodily injury, wrongful death, professional negligence or liability, or breach of any fiduciary duty, in which the offer to settle:

(i) is made by or on behalf of a claimant or is made based on or arising out of any rights of a claimant;

(ii) is delivered in writing to an allegedly responsible party's insurer for purposes of offering to settle a claim against the allegedly responsible party within any insurance policy limit of liability; and

(iii) states by its terms that it can only be accepted within a specified period of time.

History: En. Sec. 1, Ch. 352, L. 2023.

Part 3
Insurers — Noninsurance-Related Prohibitions

33-18-301. Prohibited relations with mortuaries. (1) A life insurer and its board of directors, officers, employees, or representatives that sell any life insurance, other than funeral insurance as defined in 33-20-1501(1)(c)(ii), may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.

(2) (a) A life insurer may not contract or agree with any funeral director, mortician, or undertaker that the funeral director, mortician, or undertaker shall conduct the funeral or be named beneficiary of any person insured by the insurer.

(b) A life insurer may not sell, solicit, or negotiate life insurance, except stand-alone funeral insurance as provided in 33-20-1501, through a funeral director, mortician, undertaker, or any employee of a mortuary or undertaker.

(c) A life insurer that sells, solicits, or negotiates funeral insurance, as defined in 33-20-1501(1)(c)(ii), through a funeral director, mortician, undertaker, or any employee of a mortuary or undertaker shall comply with the provisions of 33-20-1501 and 33-20-1502.

(3) A funeral insurance policy or certificate and any solicitation material for the policy must comply with 33-20-1501.

(4) An attempt by the insurer or its representative to require the insured to designate a specific beneficiary, including but not limited to a funeral director, mortician, mortuary, or undertaker, constitutes a violation of this section punishable as a misdemeanor pursuant to subsection (5).

(5) A funeral director, mortician, or undertaker or any employee of a mortuary or undertaker who seeks to sell, solicit, or negotiate funeral insurance shall comply with this code, including the requirements of Title 33, chapter 17, and Title 33, chapter 20, part 15.

(6) Each violation of this section constitutes a misdemeanor punishable by a fine of not more than $1,000 or by imprisonment for not more than 6 months, or both.

History: **En. Sec. 223, Ch. 286, L. 1959; R.C.M. 1947, 40-3521; amd. Sec. 23, Ch. 198, L. 1979; amd. Sec. 1, Ch. 229, L. 1981; amd. Sec. 55, Ch. 379, L. 1995; amd. Sec. 36, Ch. 472, L. 1999; amd. Sec. 6, Ch. 507, L. 2007; amd. Sec. 20, Ch. 151, L. 2017.**

Cross-References

Morticians — general provisions, Title 37, ch. 19, part 1.
Misdemeanor — definition, 46-18-212.

33-18-302. Defaming insurer prohibited. No person shall make, publish, disseminate, or circulate, directly or indirectly, or aid, abet, or encourage the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or derogatory to the financial condition of an insurer or of an organization proposing to become an insurer and which is calculated to injure any person engaged or proposing to engage in the business of insurance.

History: **En. Sec. 209, Ch. 286, L. 1959; R.C.M. 1947, 40-3507.**

Cross-References

Civil libel, 27-1-802.
Criminal defamation, 45-8-212.

33-18-303. Boycott, coercion, or intimidation prohibited. No person shall enter into any agreement to commit or by any concerted action commit any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in the business of insurance.

History: **En. Sec. 210, Ch. 286, L. 1959; R.C.M. 1947, 40-3508.**

Cross-References

Restraint of trade, 30-14-205.
Intimidation — criminal offense, 45-5-203.

33-18-304. Interlocking ownership and management — restrictions. (1) Any insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers or have a common management with any other insurer or insurers unless such retention, investment, acquisition, or common management is inconsistent with any other provision of this code or unless by reason thereof the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.

(2) Any person otherwise qualified may be director of two or more insurers which are competitors unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create a monopoly.

History: **En. Sec. 219, Ch. 286, L. 1959; R.C.M. 1947, 40-3517.**

Cross-References

Affiliation and merger — holding company systems, Title 33, ch. 2, part 11.

33-18-305. Political contributions prohibited — penalty. (1) No insurer shall directly or indirectly pay or use or offer, consent, or agree to pay or use any money or property for or in aid of any political party, committee, or organization or for or in aid of any corporation or other body organized or maintained for political purposes or for or in aid of any candidate for political office or for nomination for such office or for any political purpose whatsoever or for the reimbursement or indemnification of any person for money or property so used.

(2) Any officer, director, stockholder, attorney, or insurance producer of any insurer which violates any of the provisions of this section, who participates in, aids, abets, or advises or consents to any such violation and any person who solicits or knowingly receives any money or property in violation of this section shall be guilty of a misdemeanor and be punished by imprisonment for not more than 1 year and a fine of not more than $1,000; and any officer or director aiding or abetting in any contribution made in violation of this section shall be liable to the insurer for the amount so contributed.

History: **En. Sec. 220, Ch. 286, L. 1959; R.C.M. 1947, 40-3518; amd. Sec. 1, Ch. 713, L. 1989.**

Cross-References

Districting and apportionment commission disqualification for political campaign contribution, 5-1-102.
Prohibited contributions from corporations, 13-35-227.
Campaign finance, Title 13, ch. 37, part 2.
Misdemeanor, 46-18-212.

Part 4
Insured's Relations With Insurer
(Repealed)

33-18-401. Repealed. Sec. 32, Ch. 396, L. 2017.

History: **En. Sec. 224, Ch. 286, L. 1959; R.C.M. 1947, 40-3522; amd. Sec. 60, Ch. 713, L. 1989; amd. Sec. 3, Ch. 562, L. 2005.**

Part 5
Miscellaneous Prohibitions

33-18-501. Lenders — favored agent of insurer — coercion of debtors. (1) (a) A person may not require, as a condition precedent to the lending of money or extension of credit or any renewal of these, the person to whom the money or credit is extended or whose obligation a creditor is to acquire or finance to negotiate any contract of insurance or renewal of these through a particular insurer or group of insurers or a particular insurance producer or group of insurance producers.

(b) Subsection (1)(a) does not prohibit a person, a depository institution, or an affiliate of a depository institution from informing a customer or prospective customer:

(i) that insurance is required to obtain a loan or credit;

(ii) that loan or credit approval is contingent on the procurement by the customer of acceptable insurance; or

(iii) that insurance is available from the person, depository institution, or affiliate of a depository institution.

(2) A person who lends money or extends credit may not do any of the following:

(a) solicit insurance for the protection of real property, after a person indicates interest in securing a first-mortgage credit extension, until the person has received a commitment in writing from the lender as to a loan or credit extension;

(b) unreasonably reject a contract of insurance furnished by the borrower for the protection of the property securing the credit or lien. A rejection is not unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. These standards may not discriminate against any particular type of insurer or call for the rejection of an insurance contract because the contract contains coverage in addition to that required by the credit transaction.

(c) require that any consumer, borrower, mortgagor, purchaser, insurer, or insurance producer pay a separate charge in connection with the handling of any contract of insurance required as security for a loan on real estate or pay a separate charge to substitute the insurance policy of one insurer for that of another. This subsection (2)(c) does not include the interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document and does not apply to charges that would be required when the person, depository institution, or affiliate of a depository institution is the licensed producer providing the insurance.

(d) use or disclose information relative to a contract of insurance that is required by the credit transaction:

(i) for the purpose of replacing the insurance; and

(ii) without the prior written consent of the borrower;

(e) use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of, or stands behind the credit of, the person, depository institution, or affiliate of a depository institution;

(f) require any procedures or conditions of licensed insurance producers or insurers not customarily required of those insurance producers or insurers affiliated or in any way connected with the person who lends money or extends credit.

(3) Each person that lends money or extends credit and that solicits insurance primarily for personal family or household purposes or on real and personal property subject to subsection (2) must explain to the borrower in writing that the insurance related to such credit extension may be purchased from an insurer or insurance producer of the borrower's choice, subject only to the lender's right to reject a given insurer or insurance producer as provided in subsection (2)(b). The disclosure must inform the customer that the customer's choice of insurer or insurance producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen as provided in subsection (2)(b).

(4) The commissioner may examine and investigate insurance activities of any person, depository institution, affiliate of a depository institution, or insurer that the commissioner believes may be in violation of this section. The person, depository institution, affiliate of a depository institution, or insurer shall make its insurance books and records available to the commissioner and the commissioner's staff for inspection upon reasonable notice. An affected person may submit to the commissioner a complaint or material pertinent to the enforcement of this section.

(5) Nothing in this section prevents a person, a depository institution, or an affiliate of a depository institution who lends money or extends credit from placing insurance on real or personal property in the event the mortgagor, borrower, or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

(6) Nothing in this section applies to credit life or credit accident and health insurance.

(7) For the purposes of this section, the terms "depository institution" and "affiliate of a depository institution" have the same meaning as provided in 32-1-109.

History: En. 40-3516.1 by Sec. 5, Ch. 320, L. 1977; R.C.M. 1947, 40-3516.1; amd. Sec. 1, Ch. 281, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 35, Ch. 798, L. 1991; amd. Sec. 6, Ch. 229, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 6, Ch. 229, L. 2025. Amendment effective January 1, 2026.

Cross-References

Regulated lender — definition, 31-1-111.

Property insurance, Title 33, ch. 24.

33-18-502. Prohibited relations with long-term care facility. An insurance producer that owns, manages, supervises, operates, maintains, or works in a long-term care facility, as defined in 37-9-101, may not solicit, negotiate with, or sell a life or disability policy or certificate of insurance to a resident of a long-term care facility.

History: En. Sec. 5, Ch. 227, L. 2001.

Part 6
Montana Use of Credit Information in Personal Insurance

33-18-601. Short title. This part may be cited as the "Montana Use of Credit Information in Personal Insurance Act".

History: En. Sec. 1, Ch. 363, L. 2005.

33-18-602. Purpose. The purpose of this part is to regulate the use of credit information for personal insurance so that consumers are afforded certain protections with respect to the use of credit information.

History: En. Sec. 2, Ch. 363, L. 2005.

33-18-603. Scope. This part applies to personal insurance and not to commercial insurance. For purposes of this part, "personal insurance" means private passenger automobile, home owners, motorcycle, mobile home owners, and noncommercial dwelling fire insurance policies and boat, personal watercraft, snowmobile, and recreational vehicle policies. These policies must be individually underwritten for personal, family, or household use. Other types of insurance may not be included as personal insurance for the purpose of this part.

History: En. Sec. 3, Ch. 363, L. 2005.

33-18-604. Definitions. For the purposes of this part, the following definitions apply:

(1) "Adverse action" means, in regard to the terms of coverage or amount of coverage of any insurance, existing or applied for, in connection with the underwriting of personal insurance, any of the following:

(a) denial, nonrenewal, or cancellation of coverage;

(b) an increase in any charge for coverage;

(c) failure to give an otherwise available credit-related discount; or

(d) a reduction or any other adverse or unfavorable change in the terms of coverage or the amount of coverage.

(2) "Affiliate" means a company that controls, is controlled by, or is under common control with another company.

(3) "Applicant" means an individual who has applied to be covered by a personal insurance policy with an insurer.

(4) "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or of an applicant for a personal insurance policy.

(5) "Consumer reporting agency" means any entity that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

(6) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related may not be considered credit information regardless of whether it is contained in a credit report or in an application or is used to calculate an insurance score.

(7) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's creditworthiness, credit standing, or credit capacity that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

(8) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

History: En. Sec. 4, Ch. 363, L. 2005.

33-18-605. Use of credit information. (1) An insurer authorized to do business in this state that uses credit information to underwrite or rate risks may not:

(a) use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor;

(b) deny, cancel, or not renew a policy of personal insurance on the basis of credit information without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by subsection (1)(a);

(c) base an insured's renewal rates for personal insurance upon credit information without consideration of any other applicable factor independent of credit information;

(d) take an adverse action against a consumer because the consumer does not have a credit card account without consideration of any other applicable factor independent of credit information;

(e) consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance unless the insurer does one of the following:

(i) treats the consumer as otherwise approved by the commissioner if the insurer presents information that the absence or inability relates to the risk for the insurer;

(ii) treats the consumer as if the consumer had neutral credit information, as defined by the insurer; or

(iii) excludes the use of credit information as a factor and uses only other underwriting criteria;

(f) take an adverse action against a consumer based on credit information unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date that the policy is first written or renewal is issued;

(g) use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subsection (1)(g):

(i) at annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall reunderwrite and rerate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a 12-month period.

(ii) the insurer has the discretion to obtain current credit information upon any renewal before the 36 months provided for in this subsection (1)(g) if consistent with its underwriting guidelines;

(iii) an insurer may but does not have to obtain current credit information for an insured, despite the requirements of subsection (1)(g)(i), if one of the following applies:

(A) the insurer is treating the consumer as otherwise approved by the commissioner;

(B) the insured is in the most favorably priced tier of the insurer within a group of affiliated insurers;

(C) credit was not used for underwriting or rating the insured when the policy was initially written;

(D) the insurer reevaluates the insured beginning not later than 36 months after inception and at similar succeeding times based upon other underwriting or rating factors, excluding credit information.

(h) use a credit report or an insurance score that treats any of the following as a negative factor for the purpose of underwriting or rating a policy of personal insurance:

(i) credit inquiries not initiated by the consumer or inquiries requested by the consumer for the consumer's own credit information;

(ii) inquiries relating to insurance coverage, if so identified on a consumer's credit report;

(iii) collection accounts with a medical industry code, if so identified on the consumer's credit report;

(iv) multiple-lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered;

(v) multiple-lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered;

(vi) the number of credit inquiries;

(vii) the consumer's use of a particular type of credit card, charge card, or debit card or the number of credit cards obtained by a consumer;

(viii) a loan if information from the credit report makes it evident that the loan is for the purchase of an automobile or a personal residence. However, an insurer may consider the bill payment history of any loan, the total number of loans, or both.

(ix) the consumer's total available line of credit or total debt. However, an insurer may consider:

(A) the consumer's bill payment history on the debt; or

(B) the total amount of outstanding debt if the outstanding debt exceeds the total line of credit.

(2) (a) An insurer shall, on written request from an applicant or an insured, provide reasonable underwriting or rating exceptions for a consumer whose credit report has been directly affected by an extraordinary event.

(b) An insurer may require reasonable written and independently verifiable documentation of the event and the effect of the event on the consumer's credit before granting an exception. An insurer is not required to consider repeated extraordinary events or extraordinary events the insurer reconsidered previously.

(c) An insurer may also consider granting an exception to a consumer for an extraordinary event not listed in this section.

(d) An insurer may not be considered to be out of compliance with its filed rules and rates as a result of granting an exception pursuant to this subsection (2).

(e) As used in this subsection (2), "extraordinary event" means:

(i) expenses related to a catastrophic injury or illness;

(ii) temporary loss of employment;

(iii) death of an immediate family member;

(iv) theft of identity pursuant to 45-6-332; or

(v) military service overseas.

History: En. Sec. 5, Ch. 363, L. 2005; amd. Sec. 12, Ch. 227, L. 2011; amd. Sec. 1, Ch. 314, L. 2011.

33-18-606. Dispute resolution and error correction. If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 U.S.C. 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of that determination from either the consumer reporting agency or the insured, the insurer shall reunderwrite and rerate the consumer within 30 days of receiving the notice. After reunderwriting or rerating the insured, the insurer shall make any adjustments necessary consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid the premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

History: En. Sec. 6, Ch. 363, L. 2005.

33-18-607. Initial notification. (1) If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time that the insurance application is taken, that it may obtain credit information in connection with the application. The disclosure must be either written or provided to an applicant in the same medium as the application for insurance. The insurer does not have to provide the disclosure statement required under this section to any insured on a renewal policy if the consumer has previously been provided a disclosure statement.

(2) Use of the following disclosure statement constitutes compliance with this section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score."

History: En. Sec. 7, Ch. 363, L. 2005.

33-18-608. Adverse action notification. If an insurer takes an adverse action based upon credit information, the insurer shall:

(1) provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 U.S.C. 1681m(a); and

(2) provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. The notification must include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms, such as "poor credit history", "poor credit rating", or "poor insurance score",

does not meet the explanation requirements of this subsection. Standardized credit explanations provided by consumer reporting agencies or other third-party vendors are considered to comply with this section.

History: **En. Sec. 8, Ch. 363, L. 2005.**

33-18-609. Filing. (1) Insurers that use insurance scores to underwrite or rate risks shall file their scoring models or other scoring processes with the commissioner. A third party may file scoring models on behalf of insurers.

(2) A filing relating to credit information is considered a trade secret under the laws of this state.

History: **En. Sec. 9, Ch. 363, L. 2005; amd. Sec. 21, Ch. 151, L. 2017.**

33-18-610. Indemnification. An insurer shall indemnify, defend, and hold insurance producers harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of an insurance producer that obtains or uses credit information or insurance scores for an insurer if the insurance producer follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. This section may not be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

History: **En. Sec. 10, Ch. 363, L. 2005.**

33-18-611. Sale of policy term information by consumer reporting agency. (1) A consumer reporting agency may not provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. This information includes but is not limited to the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

(2) The restrictions provided in subsection (1) do not apply to data or lists that the consumer reporting agency supplies to the insurance producer from whom information was received, the insurer on whose behalf the insurance producer acted, or the insurer's affiliates or holding companies.

(3) This section may not be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

History: **En. Sec. 11, Ch. 363, L. 2005.**

33-18-612. Refund for expunged record. An insurance company that charges an additional premium based on insurance points assessed against a policyholder as a result of a charge or conviction that was expunged because of identity theft pursuant to 46-24-219 shall refund the additional premiums to the policyholder upon notification and verification of the expungement.

History: **En. Sec. 5, Ch. 195, L. 2007.**

Parts 7 and 8 reserved

Part 9
Restrictions on Use of Genetic Information

33-18-901. Definitions. Unless the context indicates otherwise, the following definitions apply to this part:

(1) "Genetic information" means, unless otherwise provided by Public Law 104-191, information derived from genetic testing or medical evaluation to determine the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are scientifically or medically believed to cause a disease, disorder, or syndrome or are associated with a statistically increased risk of developing a disease, disorder, or syndrome that is asymptomatic at the time of testing.

(2) "Genetic testing" or "genetic test" means a test used to diagnose a presymptomatic genetic factor, including analysis of human deoxyribonucleic acid or ribonucleic acid, chromosomes, proteins, or metabolites. The term does not include a routine physical examination

or a chemical, blood, or urine analysis, unless conducted or analyzed purposefully or knowingly to obtain genetic information, or a family history.

(3) "Genetic trait" means any medically or scientifically identified genetic factor, known or presumed to be present in the individual or a biological relative but not presently associated with any manifestations of the disorder in the individual, that could cause a disorder or be statistically associated with an increased risk of development of a disorder.

(4) "Group policy" includes:

(a) the group insurance program authorized by Title 2, chapter 18, part 7;

(b) the state employee group insurance program required by Title 2, chapter 18, part 8; and

(c) a self-funded multiple employer welfare arrangement that is not regulated pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.

History: En. Sec. 3, Ch. 334, L. 1999.

33-18-902. Requirement for genetic testing — limitations. (1) An insurer, health service corporation, health maintenance organization, fraternal benefit society, or other issuer of an individual or group policy or certificate of insurance may not require an individual to obtain a genetic test unless the test is otherwise required by law for reasons including but not limited to the following:

(a) to establish parentage;

(b) to determine the presence of metabolic disorders in a newborn by testing conducted pursuant to newborn screening and protocols;

(c) in connection with a criminal investigation or prosecution; or

(d) for remains identification.

(2) This section does not apply to transactions of life, disability income, or long-term care insurance.

History: En. Sec. 4, Ch. 334, L. 1999.

33-18-903. Discrimination on basis of genetic traits prohibited. (1) Unless otherwise required by law, an insurer, health service corporation, health maintenance organization, fraternal benefit society, or other issuer of an individual or group policy or certificate of insurance may not, on the basis of a person's genetic traits:

(a) fail or refuse to accept an application for a policy or certificate of insurance;

(b) fail or refuse to issue a policy or certificate of insurance to an applicant;

(c) cancel a policy or certificate of insurance;

(d) refuse to renew a policy or certificate of insurance;

(e) charge a higher rate or premium for a policy or certificate of insurance; or

(f) offer or provide different terms, conditions, or benefits or place a limitation on coverage under a policy or certificate of insurance.

(2) An insurer, health service corporation, health maintenance organization, fraternal benefit society, or other issuer of an individual or group policy or certificate of insurance may not underwrite or condition coverage on the basis of:

(a) a requirement or agreement that the individual undergo genetic testing; or

(b) genetic information about a member of the individual's family.

(3) Discrimination may not be made in the fees or commissions of agents or brokers for writing or renewing an individual or group policy of insurance on the basis of an individual's genetic traits.

(4) This section does not apply to transactions of life, disability income, or long-term care insurance.

(5) This section does not prohibit an insurer, health service corporation, health maintenance organization, fraternal benefit society, or other issuer of an individual or group policy or certificate of insurance from discriminating as otherwise allowed by law on the basis of other factors unrelated to genetic traits.

History: En. Sec. 5, Ch. 334, L. 1999.

33-18-904. Seeking genetic information for nontherapeutic purposes prohibited. (1) An insurer, health service corporation, health maintenance organization, fraternal benefit society, or other issuer of an individual or group policy or certificate of insurance may not seek genetic information about an individual for a purpose that is:

(a) unrelated to assessing or managing the individual's current health;

(b) inappropriate in an asymptomatic individual; or

(c) unrelated to research in which a subject is not personally identifiable.

(2) This section does not apply to transactions of life, disability income, or long-term care insurance.

History: En. Sec. 6, Ch. 334, L. 1999.

Part 10
Enforcement

33-18-1001. Complaint handling — marketing — performance — record. (1) An insurer shall maintain a complete record of all complaints it has received since the date of its last examination under 33-1-401. This record must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, and the time it took to process each complaint.

(2) An insurer or a health insurance lead generator shall maintain its books, records, documents, and other business records in an order that ensures data regarding complaints, claims, rating, underwriting, and marketing materials are accessible and retrievable for examination by the commissioner. The data must be maintained for at least 5 years.

(3) For the purposes of this section, "complaint" means any written communication primarily expressing a grievance.

History: En. 40-3502.2 by Sec. 2, Ch. 320, L. 1977; R.C.M. 1947, 40-3502.2; amd. Sec. 7, Ch. 229, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 7, Ch. 229, L. 2025. Amendment effective January 1, 2026.

Cross-References

Health insurance lead generators — scope and definitions, 33-18-104.

33-18-1002. Power of commissioner to examine insurers. The commissioner may examine and investigate the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by this chapter.

History: En. 40-3502.3 by Sec. 3, Ch. 320, L. 1977; R.C.M. 1947, 40-3502.3.

33-18-1003. Undefined unfair practices — procedures for determining and restraining. (1) If the commissioner believes that any person engaged in the insurance business is engaging in this state in any method of competition or in any act or practice in the conduct of the business that is not defined in this chapter but that the method of competition is unfair or that the act or practice is unfair or deceptive and that a proceeding by the commissioner in respect to the act or practice would be in the public interest, the commissioner shall, after a hearing of which notice of the hearing and of the charges against the person are given to the person, make a written report of the findings of fact relative to the charges and serve a copy of the report upon the person and any intervenor at the hearing.

(2) If the report charges a violation of this chapter and if the method of competition, act, or practice has not been discontinued, the commissioner may, through the attorney general of this state, at any time after the service of the report cause an action to be instituted to enjoin and restrain the person from engaging in the method, act, or practice. In the action, the court may grant a restraining order or injunction upon terms that may be just, but the people of this state may not be required to give security before the issuance of any order or injunction. If a stenographic record of the proceedings in the hearing before the commissioner was made, a certified transcript, including all evidence taken and the report and findings, must be received in evidence in the action.

(3) If the commissioner's report made under subsection (1) or order on hearing made under 33-18-1004 does not charge a violation of this chapter, then any intervenor in the proceedings may appeal from the report or order on hearing within the time and in the manner provided in this code for appeals from the commissioner generally.

History: En. Sec. 217, Ch. 286, L. 1959; R.C.M. 1947, 40-3515; amd. Sec. 1208, Ch. 56, L. 2009.

Cross-References

Attorney General — duties, 2-15-501.
Injunctions, Title 27, ch. 19.
Hearings by Commissioner, 33-1-701.
Appeals from Commissioner's decision, 33-1-711.
Premium changes and cancellation — property or casualty insurance — unfair trade practices, 33-15-1121.

33-18-1004. Desist orders for prohibited practices. (1) If, after a hearing of the charges of which notice of the hearing and of the charges against the person was given to the person, the commissioner finds that a person in this state has engaged or is engaging in any act or practice defined in or prohibited under this chapter, the commissioner shall order the person to desist from the acts or practices.

(2) The desist order becomes final upon expiration of the time allowed for appeals from the commissioner's orders if an appeal is not taken or, in event of an appeal, upon final decision of the court if the court affirms the commissioner's order or dismisses the appeal. An intervenor in the hearing has the right to appeal as provided in 33-18-1003(3).

(3) In event of an appeal, to the extent that the commissioner's order is affirmed, the court shall issue its own order commanding obedience to the terms of the commissioner's order.

(4) An order of the commissioner pursuant to this section or order of court to enforce it does not in any way relieve or absolve a person affected by the order from any other liability, penalty, or forfeiture under law.

(5) This section may not be considered to affect or prevent the imposition of any penalty provided by this code or by other law for violation of any other provision of this chapter, whether or not the hearing is called or held or the desist order is issued.

History: En. Sec. 216, Ch. 286, L. 1959; amd. Sec. 7, Ch. 320, L. 1977; R.C.M. 1947, 40-3514; amd. Sec. 1209, Ch. 56, L. 2009.

Cross-References

Hearings by Commissioner, 33-1-701.
Appeals from Commissioner's orders, 33-1-711.
Revocation or suspension of certificate of authority, 33-2-118, 33-2-119.

33-18-1005. Penalty for violation of cease and desist orders. (1) Any person who violates a cease and desist order issued pursuant to 33-18-1004 is subject to a civil penalty not to exceed $1,000. Each day of violation constitutes a separate violation. The total penalty may not exceed a $10,000 aggregate. The department may institute and maintain in the name of the state any enforcement proceedings hereunder. Upon request of the department, the attorney general or the county attorney of the county in which the violation occurred shall petition the district court to impose, assess, and recover the civil penalty.

(2) An action under subsection (1) of this section is not a bar to enforcement of this chapter or rules or orders made under it by injunction or other appropriate remedies.

(3) Moneys collected hereunder shall be deposited in the state general fund.

History: En. 40-3514.1 by Sec. 4, Ch. 320, L. 1977; R.C.M. 1947, 40-3514.1.

Cross-References

Attorney General — duties, 2-15-501.
County Attorneys — duties, 7-4-2716.
Legal actions by state agencies — Attorney General to be notified, 25-1-501.

33-18-1006. Desist orders for prohibited practices. Violations of 33-18-221 through 33-18-224 are subject to cease and desist orders of the commissioner issued under 33-18-1004.

History: En. Sec. 5, Ch. 554, L. 1993; amd. Sec. 37, Ch. 472, L. 1999; amd. Sec. 6, Ch. 526, L. 1999; amd. Sec. 6, Ch. 345, L. 2001; amd. Sec. 2, Ch. 407, L. 2005.

CHAPTER 19

INSURANCE INFORMATION AND PRIVACY PROTECTION

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Chapter Cross-References

Consumer reporting agencies, Title 31, ch. 3, part 1.

Part 1

General Provisions

33-19-101. Short title. This chapter may be cited as the "Insurance Information and Privacy Protection Act".

History: En. Sec. 1, Ch. 580, L. 1981.

33-19-102. Purpose. The purpose of this chapter is to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions by insurance institutions, insurance producers, or insurance-support organizations; to maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness; to establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to that information for the purpose of verifying or disputing its accuracy; to limit the disclosure of information collected in connection with insurance transactions; and to enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision. The purpose of this chapter is also to provide privacy protection consistent with federal regulations governing the privacy of medical records when this chapter is consistent with those federal regulations. In those instances in which this chapter and the federal privacy regulations are inconsistent and this chapter provides privacy protection beyond that offered by the federal regulations, the purpose of this chapter is to provide that additional privacy protection.

History: En. Sec. 2, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1, Ch. 341, L. 2001.

33-19-103. Scope. (1) The obligations imposed by this chapter apply to those insurance institutions, insurance producers, or insurance-support organizations that, on or after July 1, 1982:

(a) in the case of life, health, or disability insurance:

(i) collect, receive, or maintain information in connection with insurance transactions that pertains to natural persons who are residents of this state; or

(ii) engage in insurance transactions with applicants, individuals, or policyholders who are residents of this state; and

(b) in the case of property or casualty insurance:

(i) collect, receive, or maintain information in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state; or

(ii) engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state.

(2) The rights granted by this chapter extend to:

(a) in the case of life, health, or disability insurance, the following persons who are residents of this state:

(i) natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions; and

(ii) applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions; and

(b) in the case of property or casualty insurance, the following persons:

(i) natural persons who are the subject of information collected, received, or maintained in connection with insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state; and

(ii) applicants, individuals, or policyholders who engage in or seek to engage in insurance transactions involving policies, contracts, or certificates of insurance delivered, issued for delivery, or renewed in this state.

(3) For the purposes of this section, a person is considered a resident of this state if the person's last-known mailing address, as shown in the records of the insurance institution, insurance producer, or insurance-support organization, is located in this state.

(4) This chapter does not apply to information collected from the public records of a governmental authority and maintained by an insurance institution or its representatives for the purpose of insuring the title to real property located in this state.

History: En. Sec. 3, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-104. Definitions. As used in this chapter, the following definitions apply:

(1) (a) "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that are individually underwritten:

(i) a declination of insurance coverage;

(ii) a termination of insurance coverage;

(iii) failure of an insurance producer to apply for insurance coverage with a specific insurance institution that the insurance producer represents and that is requested by an applicant;

(iv) in the case of a property or casualty insurance coverage:

(A) placement by an insurance institution or insurance producer of a risk with a residual market mechanism, an unauthorized insurer, or an insurance institution that specializes in substandard risks; or

(B) the charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished;

(v) in the case of a life, health, or disability insurance coverage, an offer to insure at higher than standard rates.

(b) The following actions are not adverse underwriting decisions, but the insurance institution or insurance producer responsible for their occurrence shall nevertheless provide the applicant or policyholder with the specific reason or reasons for their occurrence:

(i) the termination of an individual policy form on a class or statewide basis;

(ii) a declination of insurance coverage solely because the coverage is not available on a class or statewide basis; or

(iii) the rescission of a policy.

(2) "Affiliate" or "affiliated" means a person who directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

(3) "Applicant" means a person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

(4) "Consumer report" means any written, oral, or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used in connection with an insurance transaction.

(5) "Consumer reporting agency" means a person who:

(a) regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

(b) obtains information primarily from sources other than insurance institutions; and

(c) furnishes consumer reports to other persons.

(6) "Control", including the terms "controlled by" or "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

(7) "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or insurance producer of requested insurance coverage.

(8) "Individual" means a natural person who:

(a) regarding property or casualty insurance, is a past, present, or proposed named insured or certificate holder;

(b) regarding life, health, or disability insurance, is a past, present, or proposed principal insured or certificate holder;

(c) is a past, present, or proposed policyowner;

(d) is a past or present applicant;

(e) is a past or present claimant; or

(f) derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this chapter.

(9) "Institutional source" means a person or governmental entity that provides information about an individual to an insurance producer, insurance institution, or insurance-support organization, other than:

(a) an insurance producer;

(b) the individual who is the subject of the information; or

(c) a natural person acting in a personal capacity rather than a business or professional capacity.

(10) "Insurance function" means claims administration, claims adjustment and management, fraud investigation, fraud prevention, underwriting, loss control, ratemaking functions, reinsurance, risk management, case management, disease management, quality assessment, quality improvement, provider credentialing verification, utilization review, peer review activities, subrogation, grievance procedures, insurance transactions, internal administration of compliance and policyholder service functions, and technical, administrative, or professional services related to the provision of the functions described in this subsection.

(11) (a) "Insurance institution" means a corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, or other person engaged in the business of insurance, including health maintenance organizations, and health service corporations as defined in 33-30-101.

(b) Insurance institution does not include insurance producers or insurance-support organizations.

(12) "Insurance producer" means an insurance producer as defined in 33-17-102 and 33-30-311.

(13) (a) "Insurance-support organization" means a person who assembles or collects information about natural persons for the purpose of providing the information to an insurance institution or insurance producer for insurance transactions, including:

(i) the furnishing of consumer reports or investigative consumer reports to an insurance institution or insurance producer for use in connection with an insurance transaction; or

(ii) the collection of personal information from insurance institutions, insurance producers, or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation, or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(b) The following persons are not insurance-support organizations for purposes of this chapter: insurance producers, government institutions, medical care institutions, and medical professionals.

(14) "Insurance transaction" means a transaction involving insurance primarily for personal, family, or household needs, rather than for business or professional needs, that entails:

(a) the determination of an individual's eligibility for an insurance coverage, benefit, or payment; or

(b) the servicing of an insurance application, policy, contract, or certificate.

(15) "Investigative consumer report" means a consumer report or portion of a consumer report containing information about a natural person's character, general reputation, personal characteristics, or mode of living obtained through personal interviews with the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning this type of information.

(16) "Licensee" means:

(a) an insurance institution, insurance producer, or other person who is licensed or required to be licensed, authorized or required to be authorized, or registered or required to be registered pursuant to this title; or

(b) a surplus lines insurer.

(17) "Medical care institution" means a facility or institution that is licensed to provide health care services to natural persons, including but not limited to health maintenance organizations, home health agencies, hospitals, medical clinics, public health agencies, rehabilitation agencies, and skilled nursing facilities.

(18) "Medical professional" means a person who is licensed or certified to provide health care services to natural persons, including but not limited to a chiropractor, clinical dietitian, clinical psychologist, dentist, nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, psychiatric social worker, or speech-language pathologist.

(19) "Medical record information" means personal information that:

(a) relates to an individual's physical or mental condition, medical history, medical claims history, or medical treatment; and

(b) is obtained from a medical professional or medical care institution, from the individual, or from the individual's spouse, parent, or legal guardian.

(20) "Person" means a natural person, corporation, association, partnership, or other legal entity.

(21) "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. Personal information includes an individual's name and address and medical record information but does not include privileged information.

(22) "Policyholder" means a person who:

(a) in the case of individual property or casualty insurance, is a present named insured;

(b) in the case of individual life, health, or disability insurance, is a present policyowner; or

(c) in the case of group insurance that is individually underwritten, is a present group certificate holder.

(23) "Pretext interview" means an interview during which a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

(a) pretends to be someone else;

(b) pretends to represent a person not in fact being represented;

(c) misrepresents the true purpose of the interview; or

(d) refuses to provide identification upon request.

(24) "Privileged information" means any individually identifiable information that:

(a) relates to a civil or criminal proceeding involving an individual; and

(b) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding involving an individual. Information otherwise meeting the requirements of privileged information under this subsection is considered personal information under this chapter if it is disclosed in violation of 33-19-306.

(25) "Residual market mechanism" means an association, organization, or other entity defined or described in 61-6-144.

(26) "Separate, written authorization" means an individual's written authorization that is:

(a) obtained by the recipient of personal or privileged information that has been disclosed to the recipient pursuant to 33-19-306(10), (11), (14), (15), and (17); and

(b) separate from any written authorization obtained by the disclosing insurance institution, insurance producer, or insurance-support organization.

(27) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

(28) "Unauthorized insurer" means an insurance institution that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state.

History: En. Sec. 4, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 149, Ch. 42, L. 1997; amd. Sec. 1, Ch. 258, L. 1997; amd. Sec. 1, Ch. 212, L. 1999; amd. Sec. 2, Ch. 341, L. 2001; amd. Sec. 1, Ch. 385, L. 2003.

33-19-105. Exemption based on federal standards for privacy of individually identifiable health information — notice to commissioner required — rules. (1) Except as provided in subsection (5), the obligations imposed under this chapter do not apply to a licensee that is a covered entity under the provisions of federal regulations that are part of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, parts 160 and 164, standards for privacy of individually identifiable health information or security standards for the protection of electronic health information as to any use or disclosure of personal information that is covered under the HIPAA privacy and security regulations, except for the following provisions:

(a) A notice of insurance information practices described as a notice of privacy practices for protected health information under HIPAA privacy regulations must be delivered as provided for in 33-19-202(1).

(b) To the extent that an insurer collects, discloses, or uses personal information that is not covered under the HIPAA notice of privacy practices, a separate Montana specific notice must be delivered pursuant to the provisions of 33-19-202.

(c) A disclosure authorization remains valid for a period that does not exceed 24 months, as provided for in 33-19-206(2).

(d) The reasons for an adverse underwriting decision must be specified, as provided for in 33-19-303.

(e) Disclosure of underwriting information is required, as provided for in 33-19-308.

(2) The commissioner may adopt rules regarding the exceptions from the exemption provisions described in subsection (1), including additional exceptions that embody substantive provisions of this chapter but would not be preempted by HIPAA privacy regulations.

(3) If a licensee considers itself exempt from a provision of this chapter for the reason provided in subsection (1), the licensee shall give written notice to the commissioner of that exemption and a brief statement describing why the licensee is a HIPAA-covered entity.

(4) A licensee may claim an exemption only for those lines of business that are subject to HIPAA privacy regulations. All other lines of business are subject to this chapter.

(5) A licensee exempt under subsection (1) shall comply with 33-19-321.

(6) Except as provided in subsection (7), a business associate, as defined in the HIPAA privacy regulations, 45 CFR 160.103, that is a party to a valid business associate agreement required by HIPAA privacy regulations is exempt from the provisions of this chapter, but only as to the scope of that particular agreement. Any activity of the business associate that falls outside of the scope of that agreement is subject to the provisions of this chapter.

(7) A business associate party to an agreement with a licensee exempt under subsection (1) shall comply with 33-19-321.

(8) The commissioner retains the authority to conduct complete market conduct examinations of the licensee as to the privacy policies and practices that are subject to state privacy laws.

(9) Beginning July 1, 2011:

(a) if a licensee is subject to and in compliance with a federal regulation that is part of the federal health insurance portability and accountability privacy and security regulations, 45 CFR, parts 160 and 164, and the federal regulation with which the licensee complies is inconsistent with a provision of this chapter and not less protective of consumer privacy, the licensee is exempt from compliance with the inconsistent provision of this chapter;

(b) if a licensee considers itself exempt from a provision of this chapter for the reason provided in subsection (9)(a), the licensee shall give written notice to the commissioner of that exemption unless the requirements of this subsection (9) are preempted by HIPAA privacy regulations. The notice must include a statement of the reason for the claimed exemption.

History: En. Sec. 3, Ch. 341, L. 2001; amd. Sec. 2, Ch. 385, L. 2003; amd. Sec. 22, Ch. 469, L. 2005; amd. Sec. 10, Ch. 399, L. 2007; amd. Sec. 18, Ch. 271, L. 2009; amd. Sec. 22, Ch. 151, L. 2017; amd. Sec. 16, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 16, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-19-106. Rulemaking authorized. The commissioner may adopt rules to carry out the provisions of this chapter.

History: En. Sec. 4, Ch. 341, L. 2001.

Part 2
Information Gathering

33-19-201. Pretext interviews prohibited — exception. (1) Except as provided in subsection (2), an insurance institution, insurance producer, or insurance-support organization may not use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction.

(2) A pretext interview may be undertaken to obtain information from a person or institution that does not have a generally or statutorily recognized privileged relationship with the person about whom the information relates for the purpose of investigating a claim when based upon specific information available for review by the commissioner that there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with the claim.

History: En. Sec. 5, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

Cross-References

Fraud, 28-2-404 through 28-2-406.

33-19-202. Notice of insurance information practices — delivery of notice. A licensee shall provide a clear and conspicuous notice of information practices that accurately reflects its privacy policies and practices to individuals about whom personal information is collected and disclosed by the licensee in connection with insurance transactions as follows:

(1) (a) Except as provided in subsection (2), in the case of a policyholder or certificate holder, a notice must be delivered by an insurance institution:

(i) in the case of policies issued after July 1, 2001, no later than at the time of the delivery of the insurance policy or certificate, unless the notice delivered to the policyholder or certificate holder pursuant to subsection (5)(a) when the policyholder or certificate holder was an applicant is still accurate; and

(ii) within 60 days after any material change, other than typographical, in the insurance institution's privacy policies or practices.

(b) When a policyholder or certificate holder obtains a new insurance product or service or when a policy is reinstated and any notices already provided are no longer accurate with respect to the new product, service, or reinstatement, a new or revised and accurate notice must be delivered to the policyholder or certificate holder no later than the time that the product or service is provided by the licensee or at the time of reinstatement.

(2) (a) An insurance institution is not required to meet the requirements of this section with respect to certificate holders until the insurance institution has personally identifiable information regarding the certificate holder.

(b) Until the notice requirements of subsection (1) are met, a third-party administrator or other agent or representative of an insurance institution may not disclose personal information, except as allowed in 33-19-306(2).

(3) The notice required in subsection (1) must be in writing and must state:

(a) the categories of personal information that may be collected from persons other than the individual or individuals covered;

(b) if a licensee discloses personal or privileged information to a third party without an authorization pursuant to an exception in 33-19-306 or 33-19-307, a separate description of the categories of information and the categories of third parties to whom the licensee discloses personal information;

(c) the categories of personal information about a former policyholder or certificate holder that the licensee discloses pursuant to 33-19-306 and 33-19-307 and the categories of persons to whom the disclosure may be made;

(d) any disclosure that the licensee makes pursuant to section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act, 15 U.S.C. 1681, et seq.; and

(e) the licensee's policies and practices with respect to protecting the confidentiality and security of personal and privileged information.

(4) The following information must be contained in the initial notice delivered at the time of application and in any subsequent notice:

(a) a description of the rights established under 33-19-301 and 33-19-302 and the manner in which those rights may be exercised;

(b) that information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons if the licensee collects or uses information from or discloses personal information to an insurance-support organization; and

(c) that an individual is entitled to receive, upon written request to the licensee, a record of any subsequent disclosures of medical record information, as described in 33-19-301, made by the licensee pursuant to 33-19-306 and 33-19-307.

(5) In the case of individuals who are not policyholders or certificate holders:

(a) except as provided in subsection (8), in the case of an applicant, an insurance institution shall provide a notice as described in subsection (3) when the applicant submits an application;

(b) for all other individuals, a notice must be given when a licensee seeks an authorization pursuant to 33-19-306(2) to make a disclosure that is not allowed by a disclosure exception provided for in 33-19-306(3) through (24) or 33-19-307. A notice given pursuant to this subsection (5)(b) may be in an abbreviated form and must state that:

(i) personal information may be collected from persons other than the individual or individuals proposed for coverage;

(ii) the information as well as other personal or privileged information subsequently collected by the insurance institution or insurance producer may in certain circumstances be disclosed to third parties without authorization;

(iii) a right of access and correction exists with respect to all personal information collected; and

(iv) the notice prescribed in subsection (3) must be furnished upon request. The abbreviated notice provided for in this subsection (5)(b) must explain a reasonable means by which an individual may obtain that notice.

(6) The obligations imposed by this section upon a licensee may be satisfied:

(a) by another licensee authorized to act on its behalf;

(b) by sending a notice to the primary policyholder of an individual policy or to the primary certificate holder.

(7) A licensee shall provide a notice required by this section so that an intended recipient can reasonably be expected to receive actual notice in writing or, if the intended recipient agrees, electronically, as follows:

(a) by hand-delivering a printed copy of the notice to the intended recipient;

(b) by mailing a printed copy of the notice to the last-known address of the individual separately or in a policy, billing, or other written communication; or

(c) for an individual who has agreed to conduct transactions electronically, as provided in applicable law, by posting the notice on the electronic site and requiring the individual to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service.

(8) An insurance institution may provide the notice required in subsection (5)(a) telephonically if an application is submitted by telephone. A telephone notice under this subsection may be in abbreviated form as provided for in subsections (5)(b)(i) through (5)(b)(iv).

(9) A licensee may satisfy the notice requirements in this section through the use of combined or separate notices. If more than one notice form is used, the licensee shall refer the individual to state specific notice forms that may be used. Any national notice form must give individuals clear and conspicuous notice that when state law is more protective of individuals than federal privacy law, the licensee will protect information in accordance with state law.

History: En. Sec. 6, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 2, Ch. 212, L. 1999; amd. Sec. 5, Ch. 341, L. 2001; amd. Sec. 3, Ch. 385, L. 2003; amd. Sec. 23, Ch. 151, L. 2017.

33-19-203. Marketing and research surveys. An insurance institution or insurance producer shall clearly specify the questions that are designed to obtain information from an individual in connection with an insurance transaction solely for marketing or research purposes.

History: En. Sec. 7, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-204. Repealed. Sec. 11, Ch. 341, L. 2001.

History: En. Sec. 8, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 3, Ch. 212, L. 1999.

33-19-205. Investigative consumer reports. (1) An insurance institution, insurance producer, or insurance-support organization may not prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement, or a change in insurance benefits unless the insurance institution or insurance producer informs the individual:

(a) that the individual may request to be interviewed in connection with the preparation of the investigative consumer report; and

(b) that upon a request pursuant to 33-19-301, the individual is entitled to receive a copy of the investigative consumer report.

(2) If an investigative consumer report is to be prepared by an insurance institution or insurance producer, the insurance institution or insurance producer shall institute reasonable procedures to conduct a personal interview requested by an individual.

(3) If an investigative consumer report is to be prepared by an insurance-support organization, the insurance institution or insurance producer desiring the report shall inform the insurance-support organization as to whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct the interview, if requested.

History: En. Sec. 9, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1210, Ch. 56, L. 2009.

Cross-References

Right of privacy, Art. II, sec. 10, Mont. Const.

33-19-206. Disclosure authorizations — content — conditions prohibited. If a disclosure authorization is required by this chapter, the following requirements apply:

(1) A valid authorization to disclose personal information must be in written form, or in electronic form as provided by applicable law, and must contain the following:

(a) the identity of the individual who is the subject of the personal information;

(b) a description of the types of personal information to be disclosed;

(c) a description of the entity or type of entity to which the licensee discloses personal information, the purpose of the disclosure, and how the information will be used;

(d) the signature of the individual who is the subject of the personal information or the individual who may by law allow the disclosure and the date on which the authorization is signed; and

(e) notice of the length of time for which the authorization is valid, notice that the individual may revoke the authorization at any time, and notice of the procedure for revocation.

(2) An authorization remains valid for a period stated in the authorization that does not exceed 24 contiguous months.

(3) An individual who is the subject of personal information and has signed an authorization may revoke the authorization at any time.

(4) A licensee shall retain the original authorization or a copy of it in the record of the individual who is the subject of personal information.

(5) A licensee may not condition enrollment, coverage, benefits, or rates on an individual's signing of a disclosure authorization unless the disclosure sought through the authorization is necessary for the licensee to perform an insurance function.

History: En. Sec. 6, Ch. 341, L. 2001.

Part 3
Disclosure of Information

Part Cross-References

Right of privacy, Art. II, sec. 10, Mont. Const.

33-19-301. Access to recorded personal information. (1) If an individual, after proper identification, submits a written request to an insurance institution, insurance producer, or insurance-support organization for access to recorded personal information about the individual that is reasonably described by the individual and reasonably locatable and retrievable by the insurance institution, insurance producer, or insurance-support organization, the insurance institution, insurance producer, or insurance-support organization shall, within 30 business days from the date that the request is received:

(a) inform the individual of the nature and substance of the recorded personal information in writing, by telephone, or by other oral communication, whichever the insurance institution, insurance producer, or insurance-support organization prefers;

(b) permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, whichever the individual prefers. If the recorded personal information is in coded form, an accurate translation in plain language must be provided in writing.

(c) except for the tracking of disclosures of medical record information that must be recorded and disclosed under subsection (2), disclose to the individual the identity, if recorded, of those persons to whom the insurance institution, insurance producer, or insurance-support organization has disclosed the personal information within 2 years prior to the request and, if the identity is not recorded, the names of those insurance institutions, insurance producers, insurance-support organizations, or other persons to whom the information is normally disclosed; and

(d) provide the individual with a summary of the procedures that the individual may use to request correction, amendment, or deletion of recorded personal information.

(2) (a) If an individual, after proper identification, submits a written request to a licensee for a record of disclosures of medical record information, the licensee shall provide to the individual a record of all disclosures of medical record information made by the licensee pursuant to 33-19-306(8), (9), other than disclosures made to law enforcement authorities, (10)(b), (12)(a)(iii), (13), (14), only as to medical record information that has not been de-identified, (15), (21), only as to medical record information that has not been de-identified, or (22) or 33-19-307. The record of those disclosures must include:

(i) the name, address, and institutional affiliation, if any, of each person receiving or examining the medical information during the preceding 2 years;

(ii) the date of the receipt or examination; and

(iii) to the extent practicable, a description of the information disclosed.

(b) If an individual submits a written request to a licensee for a record of disclosures of medical record information and the licensee may have made medical record information disclosures pursuant to 33-19-306(4)(b), (5), (11), (12)(a)(i), (12)(a)(ii), (12)(b), (16), (18), or (19), the licensee shall provide the individual with a description of the types of medical record information that the licensee may disclose under those exceptions, along with a general description of the usual recipients of that information. Individual tracking of each disclosure of medical record information is not required.

(3) Personal information provided pursuant to subsection (1) must identify the source of the information if the source is an institutional source.

(4) Medical record information supplied by a medical care institution or medical professional and requested under subsection (1), together with the identity of the medical professional or medical care institution that provided the information, must be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution, insurance producer, or insurance-support organization prefers. If it elects to disclose the information to a medical professional designated by the individual, the insurance institution, insurance producer, or insurance-support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional. The medical professional may review and interpret the information and, at the request of the affected individual, shall consult with the affected individual.

(5) Except for personal information provided under 33-19-303, an insurance institution, insurance producer, or insurance-support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to individuals.

(6) The obligations imposed by this section upon an insurance institution or insurance producer may be satisfied by another insurance institution or insurance producer authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under subsection (1), an insurance institution, insurance producer, or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

(7) The rights granted to individuals in this section extend to all natural persons to the extent information about them is collected, maintained, and disclosed by an insurance institution, insurance producer, or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection do not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them, except for the tracking of medical record information as provided for in subsection (2).

(8) For the purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency".

History: **En. Sec. 10, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 4, Ch. 385, L. 2003.**

33-19-302. Correction, amendment, or deletion of recorded personal information. (1) Within 30 business days from the date of receipt of a written request from an individual to correct, amend, or delete any recorded personal information in its possession about the individual, an insurance institution, insurance producer, or insurance-support organization shall either:

(a) correct, amend, or delete the portion of the recorded personal information in dispute; or

(b) notify the individual of:

(i) its refusal to make the correction, amendment, or deletion;

(ii) the reasons for the refusal; and

(iii) the individual's right to file a statement as provided in subsection (3).

(2) If the insurance institution, insurance producer, or insurance-support organization corrects, amends, or deletes recorded personal information in accordance with subsection (1)(a), the insurance institution, insurance producer, or insurance-support organization shall notify the individual in writing about the action that it has taken and furnish the correction, amendment, or fact of deletion to:

(a) any person specifically designated by the individual who may have, within the preceding 2 years, received recorded personal information about the individual;

(b) any insurance-support organization whose primary source of personal information is insurance institutions if the insurance-support organization has systematically received recorded personal information from the insurance institution within the preceding 7 years, but the correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and

(c) any insurance-support organization that furnished the personal information that has been corrected, amended, or deleted.

(3) Whenever an individual disagrees with an insurance institution's, insurance producer's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information, the individual may file with the insurance institution, insurance producer, or insurance-support organization:

(a) a concise statement setting forth what the individual thinks is the correct, relevant, or fair information; and

(b) a concise statement of the reasons why the individual disagrees with the insurance institution's, insurance producer's, or insurance-support organization's refusal to correct, amend, or delete recorded personal information.

(4) If an individual files either statement described in subsection (3), the insurance institution, insurance producer, or insurance-support organization shall:

(a) file the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it;

(b) in any subsequent disclosure by the insurance institution, insurance producer, or insurance-support organization of the recorded personal information that is the subject of disagreement, clearly identify the matter in dispute and provide the individual's statement along with the recorded personal information being disclosed; and

(c) furnish the statement to the persons in the manner specified in subsection (2).

(5) The commissioner may review a refusal by an insurance institution, insurance producer, or insurance-support organization to correct, amend, or delete recorded personal information in order to determine if the information is correct. The commissioner may order the insurance institution, insurance producer, or insurance-support organization to correct, amend, or delete information that the commissioner determines is erroneous in an individual's recorded information file.

(6) The rights granted individuals by this section extend to all natural persons to the extent information about them is collected and maintained by an insurance institution, insurance producer, or insurance-support organization in connection with an insurance transaction. The rights granted to natural persons by this subsection do not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding involving them.

(7) For the purposes of this section, the term "insurance-support organization" does not include a consumer reporting agency.

History: **En. Sec. 11, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 2, Ch. 258, L. 1997.**

33-19-303. Reasons for adverse underwriting decisions. (1) If an adverse underwriting decision is made, the insurance institution or insurance producer responsible for the decision shall:

(a) either provide the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise the person that upon written request, the person may receive the specific reason or reasons in writing; and

(b) provide the applicant, policyholder, or individual proposed for coverage with a summary of the rights established under subsection (2) and 33-19-301 and 33-19-302.

(2) If a written request is received within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder, or individual proposed for coverage, the insurance institution or insurance producer shall within 21 business days from the date of receipt of the written request furnish the person:

(a) the specific reason or reasons for the adverse underwriting decision, in writing, if the information was not initially furnished in writing pursuant to subsection (1)(a);

(b) the specific items of personal and privileged information that support those reasons; however:

(i) the insurance institution or insurance producer is not required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the commissioner, that the applicant, policyholder, or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure; and

(ii) specific items of medical record information supplied by a medical care institution or medical professional must be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution or insurance producer prefers; and

(c) the names and addresses of the institutional sources that supplied the specific items of information pursuant to subsection (2)(b), except that the identity of any medical professional or medical care institution must be disclosed either directly to the individual or to the designated medical professional, whichever the insurance institution or insurance producer prefers.

(3) The obligations imposed by this section upon an insurance institution or insurance producer may be satisfied by another insurance institution or insurance producer that is authorized to act on its behalf.

(4) When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subsection (1) may be given orally but must be made in writing at the request of the applicant, policyholder, or individual.

History: En. Sec. 12, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 3, Ch. 258, L. 1997.

Cross-References

Requirements on users of consumer reports, 31-3-131.

33-19-304. Information concerning previous adverse underwriting decisions. An insurance institution, insurance producer, or insurance-support organization may not seek information in connection with an insurance transaction concerning:

(1) any previous adverse underwriting decision experienced by an individual unless the inquiry also requests the reasons for any previous adverse underwriting decision and the individual is advised of the source of the information; or

(2) any previous insurance coverage obtained by an individual through a residual market mechanism unless the inquiry also requests the reasons why insurance coverage was previously obtained through a residual market mechanism and the individual is advised of the source of information.

History: En. Sec. 13, Ch. 580, L. 1981; amd. Sec. 8, Ch. 518, L. 1983; amd. Sec. 1, Ch. 713, L. 1989.

33-19-305. Previous adverse underwriting decisions. An insurance institution or insurance producer may not base an adverse underwriting decision in whole or in part:

(1) on the fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism, but an insurance institution or insurance producer may base an adverse underwriting decision on further information obtained from an insurance institution or insurance producer responsible for a previous adverse underwriting decision;

(2) on personal information received from an insurance-support organization whose primary source of information is insurance institutions, but an insurance institution or insurance producer may base an adverse underwriting decision on further personal information obtained as the result of information received from such insurance-support organization.

History: En. Sec. 14, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-306. Disclosure limitations and conditions. (1) Except as provided in this section, a licensee may not disclose personal or privileged information about an individual collected or received in connection with an insurance transaction.

(2) Disclosure may be made with the written authorization of the individual. The authorization must be in the form provided in 33-19-206.

(3) Disclosure limited to that which is reasonably necessary may be made to a person to enable the person to provide information to the disclosing licensee for the purpose of detecting or preventing criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction. A person to whom information is disclosed pursuant to this subsection shall agree in writing not to further disclose the information, but this requirement for an agreement does not prevent disclosure of information that is necessary to obtain further information for the purposes set forth in this subsection.

(4) (a) Disclosure may be made between licensees if the information disclosed is limited to that which is reasonably necessary:

(i) to detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with insurance transactions; or

(ii) for either the disclosing or receiving licensee to perform its insurance function.

(b) A licensee receiving information pursuant to this subsection (4) may not further disclose the information unless otherwise permitted by this section.

(5) Disclosure may be made to a medical care institution, a medical professional, or the individual to whom the information pertains if that information is reasonably necessary for the following purposes:

(a) verifying insurance coverage or benefits;

(b) informing an individual of a medical problem of which the individual may not be aware;

(c) conducting an operations or services audit; or

(d) determining the reasonableness or necessity of medical services.

(6) Disclosure:

(a) may be made to an insurance regulatory authority;

(b) must be made as required by law; and

(c) must be or may be made to the commissioner as required or permitted by law.

(7) Disclosure may be made by a licensee or an insurance-support organization to a law enforcement or other government authority or to an insurance regulatory agency:

(a) to protect the interests of a licensee in preventing, investigating, or prosecuting the perpetration of fraud upon a licensee;

(b) if the licensee or insurance-support organization reasonably believes that illegal activities have been conducted by the individual; or

(c) as provided in 61-6-157.

(8) Disclosure that is limited to that which is reasonably necessary may be made as otherwise permitted or required by law.

(9) Disclosure that is limited to that which is reasonably necessary may be made in response to a facially valid administrative or judicial order, including a search warrant or subpoena.

(10) (a) Except as provided in subsection (10)(b), disclosure that is limited to that which is reasonably necessary may be made for the purpose of conducting actuarial or research studies if:

(i) an individual is not identified in any actuarial or research report;

(ii) materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed; and

(iii) the actuarial or research organization agrees not to further disclose the information without the individual's separate, written authorization.

(b) Disclosure of information may be made for:

(i) health research that is subject to the approval of an institutional review board and the requirements of federal law and regulations governing biomedical research; or

(ii) epidemiological or drug therapy outcomes research that requires information that has been made anonymous to protect the identity of the patient through coding or encryption.

(11) Disclosure may be made to a party or a representative of a party to a proposed sale, transfer, merger, or consolidation of all or part of the business of the licensee or insurance-support organization if:

(a) prior to the consummation of the sale, transfer, merger, or consolidation only information that is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger, or consolidation is disclosed; and

(b) the recipient agrees not to further disclose the information without the individual's separate, written authorization.

(12) (a) Disclosure that is limited to that which is reasonably necessary may be made to a licensee's affiliate as follows:

(i) to allow use of the information in connection with an audit of the licensee;

(ii) to enable a licensee to perform an insurance function; or

(iii) as allowed by 33-19-307.

(b) A licensee disclosing pursuant to this section must have a written agreement with the affiliate that the affiliate will not use or further disclose information received except to carry out the purposes set forth in subsection (12)(a) and that if further disclosure is necessary to meet those purposes, the disclosure will be made only to the licensee or to a person who agrees in writing to be bound by the same prohibition on use and disclosure. A disclosure allowed by 33-19-307 is governed by that section.

(13) Disclosure that is limited to that which is reasonably necessary may be made to an insurance-support organization to perform insurance-support services for the licensee. The insurance-support organization may redisclose the information to the extent necessary to provide its services to its member or subscriber licensees and other insurance-support organizations or as otherwise permitted by law, but not for a marketing purpose.

(14) Disclosure may be made to a group policyholder for the purpose of reporting claims experience or conducting an audit of the licensee's operations or services if the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit and the group policyholder agrees not to further disclose the information without the individual's separate, written authorization. Medical record information disclosed pursuant to this subsection must be edited to prevent the identification of the applicant, policyholder, or certificate holder. Employer audits that are required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq., as amended, are not subject to the provisions of this subsection.

(15) Disclosure that is limited to that which is reasonably necessary may be made to a professional peer review organization for the purpose of reviewing the service or conduct of a medical care institution or medical professional if the professional peer review organization agrees not to further disclose the information without the individual's separate, written authorization.

(16) Disclosure that is limited to that which is reasonably necessary may be made to a governmental authority as required by federal or state law or for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable.

(17) Disclosure that is limited to that which is reasonably necessary may be made to a certificate holder or policyholder for the purpose of providing information regarding the status of an insurance transaction. Disclosure pursuant to this subsection may not be made to a group policyholder without a separate, written authorization from the individual.

(18) Disclosure may be made to a person contractually engaged to provide services to enable a licensee to perform an insurance function, or to perform an insurance function on behalf of a licensee, if the person agrees in writing that the person will not use or further disclose information obtained or developed pursuant to the engagement except to carry out the limited purpose of the engagement and that if further disclosure is necessary to perform the insurance function, that disclosure will be made only to the licensee or to a person who agrees in writing to be bound by the same prohibitions on use and disclosure.

(19) If a licensee has to disclose personal or privileged information in order to perform an insurance function and disclosure is not permitted under another exception in this section, disclosure may be made to a person other than a licensee if the disclosure is limited to that which is reasonably necessary to enable the person to perform services or an insurance function for the disclosing licensee and if the person is notified by the licensee that the person is prohibited from:

(a) using the information other than to carry out the limited purpose for which the information is disclosed; and

(b) disclosing the information other than to the licensee and as allowed in subsection (3).

(20) Disclosure may be made to a lienholder, mortgagee, assignee, lessor, or other person shown on the records of an insurance institution or insurance producer as having a legal interest in a policy of insurance if:

(a) medical record information is not disclosed; and

(b) the information disclosed is limited to that which is reasonably necessary to permit the person with a legal interest in the policy to protect that person's interests in that policy.

(21) Disclosure may be made to provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants, and auditors if the disclosure is limited to that which is reasonably necessary to enable the person or entity to perform services or an insurance function for the disclosing licensee and if the person or entity is notified by the licensee that the person or entity is prohibited from using the information, other than to carry out the limited purpose for which the information is disclosed.

(22) Notwithstanding any other provision of this chapter, disclosure for a marketing purpose may be made only as allowed by 33-19-307.

(23) This section may not be construed to prevent the disclosure of personal information that is otherwise discoverable pursuant to the Montana Rules of Civil Procedure.

(24) The commissioner may adopt rules creating additional exceptions to disclosure restrictions for the purpose of allowing a licensee or insurance-support organization to carry out a necessary insurance function. The commissioner shall adopt rules establishing the methods that must be used by licensees to prevent identification as described in subsection (14).

History: En. Sec. 15, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 4, Ch. 212, L. 1999; amd. Sec. 7, Ch. 341, L. 2001; amd. Sec. 5, Ch. 385, L. 2003; amd. Sec. 6, Ch. 413, L. 2009.

33-19-307. Personal information used for marketing purposes — restrictions. (1) Except as permitted in this section, a licensee may not use or disclose personal information for a marketing purpose. For the purposes of this section, an insurance producer who describes to the producer's clients products or services available through the producer is not engaged in marketing.

(2) A licensee may use or disclose to another licensee personal information that is reasonably necessary to enable the licensee to market insurance products or services. A licensee may use or disclose to another licensee personal information, excluding medical record information, that is reasonably necessary to enable the licensee to market financial products and services. A licensee that receives personal information under this section from a disclosing licensee may not further disclose the information or use the information for any purpose other than marketing insurance and financial products and services.

(3) A licensee may disclose personal information that is reasonably necessary to enable an affiliate that is not a licensee to market insurance products and services. A licensee may disclose to an affiliate that is not a licensee personal information, excluding medical record information, that is reasonably necessary to enable the affiliate to market financial products and services. Disclosures under this subsection may be made only with a written agreement with the affiliate that the affiliate will not further disclose the information and will use it only for marketing insurance or financial products and services.

(4) A licensee may disclose personal information that is reasonably necessary to enable a person contractually engaged to provide services for or on behalf of the licensee to market insurance or financial products or services if the person agrees in writing that the person will not use or further disclose information obtained or developed pursuant to the engagement except to carry out the limited purpose of the engagement. A licensee shall adopt and maintain policies and procedures reasonably designed to ensure that third parties with whom the licensee contracts under this subsection comply with the requirements of this section.

(5) A licensee may use or disclose personal information for purposes other than those specified in subsections (2) through (4) only with an individual's written authorization as described in 33-19-306(2). In addition to meeting the requirements of 33-19-206, the authorization must:

(a) clearly and conspicuously state that the disclosed information is intended to be used for marketing purposes;

(b) specify each entity or type of entity to which the licensee intends to disclose the information;

(c) specify what information the licensee intends to disclose; and

(d) specify the type of marketing that the individual might receive pursuant to the disclosure.

History: **En. Sec. 8, Ch. 341, L. 2001; amd. Sec. 6, Ch. 385, L. 2003.**

33-19-308. Disclosure of underwriting information. (1) An insurance institution or insurance-support organization shall, within 30 days of receiving a written request from an entity listed in subsection (2) that it provides coverage for, disclose to that entity the following information that the entity specifically requests about the entity's coverage:

(a) total premiums collected from the entity for the policy year; and

(b) total losses paid out with respect to the entity for the policy year.

(2) Any of the following entities may request information about the entity's coverage pursuant to this section:

(a) an association having a group health insurance program for its members;

(b) a group purchasing cooperative;

(c) a group health plan that is a multiple employer welfare arrangement;

(d) a self-insured group; and

(e) a business that provides group health insurance for its employees, except that a business with between 2 and 50 employees is not subject to the provisions of this section.

(3) Information disclosed pursuant to this section may not include any personal information pertaining to an individual covered by a group plan that has been obtained or administered by an entity listed in subsection (2).

(4) Information that is obtainable pursuant to the provisions of this section may not be requested more than once during any calendar year.

(5) An association provided for in subsection (2)(a) must be provided with reasonable information by its insurance institution or insurance-support organization to enable the association to receive a bid or quote for coverage from other insurance entities.

History: **En. Sec. 1, Ch. 471, L. 2001.**

33-19-309. *(Effective July 1, 2026)* **Health carrier and patient access to health information — exemption — deadline extensions.** (1) A health carrier as defined in 33-2-2402 shall establish and maintain the following application programming interfaces for the benefit of the carrier's insureds and contracted providers:

(a) a patient access application programming interface, pursuant to 42 CFR 422.119(a) through 422.119(e);

(b) a provider directory application programming interface, pursuant to 42 CFR 422.120;

(c) a provider access application programming interface, pursuant to 42 CFR 422.121(a);

(d) a payer-to-payer exchange application programming interface, pursuant to 42 CFR 422.121(b); and

(e) a prior authorization application programming interface, pursuant to section 42 CFR 422.122.

(2) A health carrier shall establish and maintain each application programming interface provided for in subsection (1) for the health carrier's insured and providers at the earliest date required by the centers for medicare and medicaid services for that type of application programming interface.

(3) An application programming interface must comply with standards published by the centers for medicare and medicaid services, including effective dates, enforcement delays, and suspensions.

(4) This section does not apply to a health carrier offering a dental only or vision only plan.

(5) (a) The commissioner may extend the deadlines described in this section.

(b) To obtain an extension, a health carrier shall submit a request in writing demonstrating that compliance:

(i) would be unduly burdensome, impracticable, or unfeasible; and

(ii) would result in economic harm to the carrier or other stakeholders.

(c) An extension must be granted in writing, including the commissioner's reasoning for the decision to extend.

(d) An approved extension must be published on the commissioner's website.

(6) For the purposes of this section, "commissioner" means the insurance commissioner of the state of Montana.

History: **En. Sec. 1, Ch. 694, L. 2025.**

Compiler's Comments

Effective Date: Section 5, Ch. 694, L. 2025, provided: "[This act] is effective July 1, 2026."

33-19-310 through 33-19-320 reserved.

33-19-321. Computer security breach. (1) Any licensee or insurance-support organization that conducts business in Montana and that owns or licenses computerized data that includes personal information shall provide notice of any breach of the security of the system following discovery or notice of the breach of the security of the system to any individual whose unencrypted personal information was or is reasonably believed to have been acquired by an unauthorized person. The notice must be made without unreasonable delay, consistent with the legitimate needs of law enforcement, as provided in subsection (3), or consistent with any measures necessary to determine the scope of the breach and restore the reasonable integrity of the data system.

(2) Any person to whom personal information is disclosed in order for the person to perform an insurance function pursuant to this part that maintains computerized data that includes personal information shall notify the licensee or insurance-support organization of any breach of the security of the system in which the data is maintained immediately following discovery of the breach of the security of the system if the personal information was or is reasonably believed to have been acquired by an unauthorized person.

(3) The notice required by this section may be delayed if a law enforcement agency determines that the notice will impede a criminal investigation and requests a delay of notice. The notice required by this section must be made after the law enforcement agency determines that the notice will not compromise the investigation.

(4) Licensees, insurance-support organizations, and persons to whom personal information is disclosed pursuant to this part shall develop and maintain an information security policy for the safeguarding of personal information and security breach notice procedures that provide expedient notice to individuals as provided in subsection (1).

(5) Any licensee or insurance-support organization that is required to issue a notification pursuant to this section shall simultaneously submit an electronic copy of the notification and a statement providing the date and method of distribution of the notification to the commissioner, excluding any information that personally identifies any individual who is entitled to receive notification. If a notification is made to more than one individual, a single copy of the notification must be submitted that indicates the number of individuals in the state who received notification.

(6) For purposes of this section, the following definitions apply:

(a) "Breach of the security of the system" means unauthorized acquisition of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by a licensee, insurance-support organization, or person to whom information is disclosed pursuant to this part. Acquisition of personal information by a licensee, insurance-support organization, or employee or agent of a person as authorized pursuant to this part is not a breach of the security of the system.

(b) (i) "Personal information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when the name and the data elements are not encrypted:

(A) social security number;

(B) driver's license number, state identification card number, or tribal identification card number;

(C) account number or credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account;

(D) medical record information;

(E) a taxpayer identification number; or

(F) an identity protection personal identification number issued by the United States internal revenue service.

(ii) Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

History: En. Sec. 9, Ch. 518, L. 2005; amd. Sec. 4, Ch. 180, L. 2007; amd. Sec. 4, Ch. 62, L. 2015.

Part 4
Enforcement

33-19-401. Power of the commissioner. (1) The commissioner has the power to examine and investigate the affairs of every insurance institution or insurance producer doing business in this state to determine whether the insurance institution or insurance producer has been or is engaged in any conduct in violation of this chapter.

(2) The commissioner has the power to examine and investigate the affairs of every insurance-support organization acting on behalf of an insurance institution or insurance producer that either transacts business in this state or transacts business outside this state which has an effect on a person residing in this state in order to determine whether such insurance-support organization has been or is engaged in any conduct in violation of this chapter.

History: En. Sec. 16, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-402. Repealed. Sec. 11, Ch. 341, L. 2001.

History: En. Sec. 17, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-403. Service of process — insurance-support organizations. For the purpose of this chapter, an insurance-support organization transacting business outside this state that has an effect on a person residing in this state is considered to have appointed the commissioner to accept service of process on its behalf. The party seeking service and the commissioner shall follow the procedure in 33-1-606 to effectuate service.

History: En. Sec. 18, Ch. 580, L. 1981; amd. Sec. 10, Ch. 60, L. 2019.

33-19-404. Repealed. Sec. 11, Ch. 341, L. 2001.

History: En. Sec. 19, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-405. Civil penalty. A person who violates this chapter is subject to the civil penalty provided in 33-1-317.

History: En. Sec. 20, Ch. 580, L. 1981; amd. Sec. 4, Ch. 101, L. 1985; amd. Sec. 9, Ch. 341, L. 2001.

33-19-406. Repealed. Sec. 11, Ch. 341, L. 2001.

History: En. Sec. 21, Ch. 580, L. 1981; amd. Sec. 5, Ch. 101, L. 1985.

33-19-407. Individual remedies. (1) If any insurance institution, insurance producer, or insurance-support organization fails to comply with 33-19-301, 33-19-302, or 33-19-303 with respect to the rights granted under those sections, any person whose rights are violated may apply to the district court of this state or any other court of competent jurisdiction for appropriate equitable relief.

(2) An insurance institution, insurance producer, or insurance-support organization that discloses information in violation of 33-19-306 or 33-19-307 is liable for damages sustained by the individual to whom the information relates. However, an individual is not entitled to a monetary award that exceeds the actual damages sustained by the individual as a result of a violation of 33-19-306 or 33-19-307.

(3) In an action brought pursuant to this section, the court may award the cost of the action and reasonable attorney fees to the prevailing party.

(4) An action under this section must be brought within 2 years from the date the alleged violation is or should have been discovered.

(5) Except as specifically provided in this section, there is no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provision of this chapter.

History: En. Sec. 22, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 10, Ch. 341, L. 2001.

33-19-408. Immunity. A cause of action or claim for relief in the nature of defamation, invasion of privacy, or negligence does not arise against any person for disclosing personal or privileged information in accordance with this chapter, nor does such a cause of action or claim for relief arise against any person for furnishing personal or privileged information to an insurance institution, insurance producer, or insurance-support organization. However, this section does not provide immunity for disclosing or furnishing false information with malice or willful intent to injure any person.

History: En. Sec. 23, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-409. Obtaining information under false pretenses. Any person who knowingly and willfully obtains information about an individual from an insurance institution, insurance producer, or insurance-support organization under false pretenses shall be fined not more than $10,000 or imprisoned for not more than 1 year, or both.

History: En. Sec. 24, Ch. 580, L. 1981; amd. Sec. 1, Ch. 713, L. 1989.

33-19-410. Repealed. Sec. 32, Ch. 396, L. 2017.

History: En. Sec. 5, Ch. 276, L. 2007.

CHAPTER 20
LIFE INSURANCE

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Chapter Cross-References

Police protective association — salary deduction for group life insurance, 7-32-4122.
Deferred compensation — used to purchase life insurance and annuities, 19-50-102.
Assignments for benefit of creditors — exemption for general assignment, 31-2-227.
Denial of insurance — credit report — consumer's rights, 31-3-131.
Life insurance — definition, 33-1-208.
Discrimination in insurance and retirement plans, 49-2-309.
Disposition of unclaimed property, Title 70, ch. 9.
Physicians' liens — exemptions, 71-3-1118.
Homicide — effect on life insurance, 72-2-813.

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Commissioner to approve policy forms, Title 33, ch. 1, part 5.
Living will declaration — not required as condition for insurance coverage, 50-9-205.
Living wills — effect on insurance, 50-9-205.

33-20-101. Scope. (1) Except as provided in subsection (2), parts 1 through 5 of this chapter apply only to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

(2) Sections 33-20-114, 33-20-131, and 33-20-150 also apply to group life insurance, and 33-20-114, 33-20-124, and 33-20-150 also apply to group annuities.

History: En. Sec. 295, Ch. 286, L. 1959; R.C.M. 1947, 40-3801; amd. Sec. 149, Ch. 575, L. 1981; amd. Sec. 6, Ch. 699, L. 1991; amd. Sec. 22, Ch. 451, L. 1993; amd. Sec. 28, Ch. 531, L. 1997; amd. Sec. 2, Ch. 76, L. 1999; amd. Sec. 24, Ch. 380, L. 2003.

Cross-References

Accidental death incidental to casualty insurance, 33-1-206.
Reinsurance — general provisions, Title 33, ch. 2, part 12.
Group life insurance, Title 33, ch. 20, parts 10 through 12.

33-20-102. Industrial life insurance defined. For the purposes of this code, industrial life insurance is that form of life insurance written under policies of face amount of $2,000 or less bearing the words "industrial policy" imprinted on the face thereof as part of the descriptive matter and under which premiums are payable monthly or more often.

History: En. Sec. 296, Ch. 286, L. 1959; amd. Sec. 1, Ch. 30, L. 1969; R.C.M. 1947, 40-3802.

Cross-References

Attachment of application as evidence — exception, 33-15-402.

33-20-103. Standard provisions required — exceptions. (1) A policy of life insurance, other than group and pure endowments with or without return of premiums or of premiums and interest, may not be delivered or issued for delivery in this state unless it contains in substance all of the applicable provisions as required by 33-20-104 through 33-20-108, 33-20-110 through 33-20-116, and 33-20-131.

(2) This section does not apply to annuity contracts or to any provision of a life insurance policy, or contract supplemental to an annuity contract or life insurance policy, relating to disability benefits or to additional benefits in the event of death by accident or accidental means. However, the provisions of 33-20-114 do apply to annuity contracts.

(3) Any provision or portions of a provision not applicable to single premium or term policies may not to that extent be incorporated in single premium or term policies.

History: En. Sec. 297, Ch. 286, L. 1959; R.C.M. 1947, 40-3803; amd. Sec. 83, Ch. 370, L. 1987; amd. Sec. 25, Ch. 380, L. 2003.

33-20-104. Grace period. There shall be a provision that a grace period of 30 days or, at the option of the insurer, of 1 month of not less than 30 days or of 4 weeks in the case of industrial life insurance policies, the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force; but if a claim arises under the policy during such period of grace, the amount of any premium due or overdue may be deducted from the policy proceeds.

History: En. Sec. 298, Ch. 286, L. 1959; R.C.M. 1947, 40-3804.

Cross-References

Computation of time — which days counted, 1-1-306.

33-20-105. Incontestability. (1) There must be a provision that the policy, exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means, is incontestable, except for nonpayment of premiums, after the policy has been in force during the lifetime of the insured for a period of 2 years from the policy date of issue.

(2) (a) Life insurance coverage issued as the result of an exchange or a conversion of existing life insurance coverage with the same insurer or its subsidiaries is incontestable, except for nonpayment of premiums, under the following conditions:

(i) the person who is covered is alive; and

(ii) the policy that is being exchanged or converted has been in effect for 2 years from the date of issue.

(b) This subsection (2) does not apply to any amount of insurance provided by the new policy that exceeds the coverage amount that was exchanged or converted.

History: En. Sec. 299, Ch. 286, L. 1959; R.C.M. 1947, 40-3805; amd. Sec. 26, Ch. 380, L. 2003; amd. Sec. 23, Ch. 469, L. 2005.

33-20-106. Entire contract. There shall be a provision that the policy, or the policy and the application therefor if a copy of such application is endorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties and, if the application is so made a part of the policy, that all statements contained in the application shall, in the absence of fraud, be deemed representations and not warranties.

History: En. Sec. 300, Ch. 286, L. 1959; R.C.M. 1947, 40-3806.

Cross-References

Interpretation of instruments, Title 1, ch. 4, part 1.
Fraud, 28-2-404 through 28-2-406.
Interpretation of written contracts — statute of frauds, Title 28, ch. 2, part 9.
Representations and warranties — applications other than life insurance, 33-15-403.

33-20-107. Misstatement of age. There shall be a provision that if the age of the insured or of any other person whose age is considered in determining the premium has been misstated, any amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages.

History: En. Sec. 301, Ch. 286, L. 1959; R.C.M. 1947, 40-3807.

33-20-108. Dividends. (1) There shall be a provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy, provided the policy is in force and all premiums to that date are paid.

(2) Except as hereinafter provided, any dividend becoming payable shall at the option of the party entitled to elect such option be either:

(a) payable in cash; or

(b) applied to any one of such other dividend options as may be provided by the policy.

(3) If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if such party shall not have elected some other option. If the policy specifies a period within which such other dividend option may be elected, such period shall be not less than 30 days following the date on which such dividend is due and payable.

(4) The annually apportioned dividend shall be deemed to be payable in cash within the meaning of subsection (2)(a) above even though the policy provides that payment of such

dividend is to be deferred for a specified period, provided such period does not exceed 6 years from the date of apportionment and that interest will be added to such dividend at a specified rate.

(5) If a participating policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus becoming payable or apportioned while the insurance is in force under such nonforfeiture provision shall be applied in the manner set forth in the policy.

(6) In participating industrial life insurance policies, in lieu of the provision required in subsections (1) through (5) above, there shall be a provision that, beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus, if any, in the manner set forth in the policy.

History: En. Sec. 302, Ch. 286, L. 1959; R.C.M. 1947, 40-3808.

Cross-References

Standard nonforfeiture law — life insurance, Title 33, ch. 20, part 2.
Standard nonforfeiture law — individual deferred annuities, Title 33, ch. 20, part 5.

33-20-109. Renumbered 33-20-131. Code Commissioner, 1985.

33-20-110. Table of values. There shall be a table showing in figures the loan value, if required under 33-20-131, and the cash surrender values and nonforfeiture benefits in accordance with 33-20-202(1)(e), either during the first 20 policy years or during the term of the policy, whichever is shorter.

History: En. Sec. 304, Ch. 286, L. 1959; R.C.M. 1947, 40-3810.

33-20-111. Table of installments. In case the policy provides that the proceeds may be payable in installments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed installments.

History: En. Sec. 305, Ch. 286, L. 1959; R.C.M. 1947, 40-3811.

33-20-112. Reinstatement. There shall be a provision that the policy will be reinstated at any time within 3 years, or 2 years in the case of industrial life insurance policies, from the date of premium default upon written application therefor, the production of evidence of insurability satisfactory to the insurer, the payment of all premiums in arrears, and the payment or reinstatement of any other indebtedness to the insurer upon the policy, with interest on all premiums in arrears at a rate not exceeding 6% per annum compounded annually and with interest on any indebtedness at a rate as provided in 33-20-132 through 33-20-136, unless:

(1) the policy has been surrendered for its cash surrender value;
(2) its cash surrender value has been exhausted; or
(3) the paid-up term insurance, if any, has expired.

History: En. Sec. 306, Ch. 286, L. 1959; R.C.M. 1947, 40-3812; amd. Sec. 7, Ch. 191, L. 1985.

33-20-113. Payment of premiums. There shall be a provision relative to the payment of premiums.

History: En. Sec. 307, Ch. 286, L. 1959; R.C.M. 1947, 40-3813.

33-20-114. Payment of claims — interest. (1) There must be a provision, which may be made by endorsement, that when a claim is made upon the death of the insured, settlement must be made upon receipt of proof of death and, at the insurer's option, surrender of the policy or proof of the interest of the claimant, or both.

(2) There must be a provision, which may be made by endorsement, that settlement must be made within 60 days of receipt of proof of death and that if settlement is made after the first 30 days, the settlement must include interest from the 30th day until settlement. Interest must be paid at the monthly average discount rate on 90-day AA asset-backed commercial paper in effect at the federal reserve bank in the ninth federal reserve district at the time of proof of death or at the rate stated in the policy, whichever is greater. The settlement period and interest provisions of this subsection apply to all claims upon deaths filed with an insurer, regardless of whether those provisions are included in the policy.

History: En. Sec. 308, Ch. 286, L. 1959; R.C.M. 1947, 40-3814; amd. Sec. 1, Ch. 469, L. 1985; amd. Sec. 27, Ch. 380, L. 2003; amd. Sec. 15, Ch. 63, L. 2015.

Cross-References

Unfair trade practice — delay caused by requiring multiple proofs of loss, 33-18-201.
Administrative penalty for failure to pay claims promptly, 33-18-232 through 33-18-235.

33-20-115. Beneficiary — industrial policies. (1) An industrial life insurance policy shall have the name of the beneficiary designated thereon with a reservation of the right to designate or change the beneficiary after the issuance of the policy.

(2) The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until endorsed on the policy by the insurer and that the insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured.

(3) The policy may also provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than 30 days after the death of the insured, or if the beneficiary is the estate of the insured or is a minor or dies before the insured or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the personal representative of the insured or to any relative of the insured by blood or legal adoption or connection by marriage or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary or by reason of having incurred expense for the maintenance, medical attention, or burial of the insured.

(4) The policy may also include a similar provision applicable to any other payment due under the policy.

(5) The provisions of 33-20-114(2) shall be incorporated into an industrial life insurance policy and are applicable as set out in that subsection.

History: En. Sec. 309, Ch. 286, L. 1959; R.C.M. 1947, 40-3815; amd. Sec. 150, Ch. 575, L. 1981; amd. Sec. 2, Ch. 469, L. 1985.

33-20-116. Title. There shall be a title on the policy, briefly describing the same.

History: En. Sec. 310, Ch. 286, L. 1959; R.C.M. 1947, 40-3816.

33-20-117. Nonforfeiture rights — policies issued before operative date. (1) This section applies only to policies of life insurance issued prior to the operative date of 33-20-213.

(2) In the event of default in payment of any premium due on any policy, if not less than 3 full years' premiums have been paid, there must be secured to the insured, without action on the insured's part, either paid-up or extended insurance as specified in the policy, the net value of which must be at least equal to the entire net reserve held by the insurer of the policy, less 2½% of the amount insured by the policy and dividend additions, if any, and less any outstanding indebtedness to the insurer on the policy at the time of default. There must be secured to the insured the right to surrender the policy to the insurer at its home office within 1 month after the date of default for cash value otherwise available for the purchase of the paid-up or extended insurance.

History: En. Sec. 326, Ch. 286, L. 1959; R.C.M. 1947, 40-3832; amd. Sec. 1211, Ch. 56, L. 2009.

33-20-118. Contestability — excluded or restricted coverage. A clause in any policy of life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause.

History: En. Sec. 311, Ch. 286, L. 1959; R.C.M. 1947, 40-3817.

33-20-119. Incontestability — limitation on liability after reinstatement of life insurance or annuity. (1) A reinstated policy of life insurance or annuity contract may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides with respect to contestability after original issuance.

(2) When any life insurance policy or annuity contract is reinstated, such reinstated policy or contract may exclude or restrict liability to the same extent that such liability might have been or was excluded or restricted when the policy or contract was originally issued, and such exclusion or restriction shall be effective from the date of reinstatement.

History: En. Sec. 322, Ch. 286, L. 1959; R.C.M. 1947, 40-3828.

33-20-120. Policy settlements — holding proceeds — indebtedness deducted from proceeds. (1) Any life insurer shall have the power to hold under agreement the proceeds of any policy issued by it, upon such terms and restrictions as to revocation by the policyholder and control by beneficiaries and with such exemptions from the claims of creditors of beneficiaries other than the policyholder as set forth in the policy or as agreed to in writing by the insurer and the policyholder. Upon maturity of a policy, in the event the policyholder has made no such agreement, the insurer shall have the power to hold the proceeds of the policy under an agreement with the beneficiaries. The insurer shall not be required to segregate the funds so held but may hold them as part of its general assets.

(2) In determining the amount due under any life insurance policy heretofore or hereafter issued, deduction may be made of:

(a) any unpaid premiums or installments thereof for the current policy year due under the terms of the policy; and

(b) the amount of principal and accrued interest of any policy loan or other indebtedness against the policy then remaining unpaid.

History: En. Secs. 323, 324, Ch. 286, L. 1959; R.C.M. 1947, 40-3829, 40-3830.

33-20-121. Prohibited provisions — limitations on liability. (1) A policy of life insurance may not be delivered or issued for delivery in this state if it contains a provision:

(a) for a period shorter than that provided by statute within which an action at law or in equity may be commenced on the policy; or

(b) that excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified in the policy in the event of death:

(i) as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces or of an act or hazard of war or action or of service in the military, naval, or air forces or in civilian forces auxiliary to those military forces or from any cause while a member of military, naval, or air forces of a country at war, declared or undeclared, or of a country engaged in military action;

(ii) as a result of aviation, air travel, or flight;

(iii) as a result of a specified hazardous occupation or occupations;

(iv) while the insured is a resident outside the continental United States and Canada; or

(v) within 2 years from the date of issue of the policy as a result of suicide. If a life insurance policy contains a dependent rider, the dependent coverage may be continued upon payment of the premium for the dependent rider.

(2) A policy that contains an exclusion or restriction pursuant to subsection (1) must also provide that in the event of death under the circumstances to which the exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the commissioner's reserve valuation method on the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits or, if the policy does not provide for nonforfeiture benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy or by any other method more favorable to the policyholder, with adjustment for indebtedness or dividend credit.

(3) This section does not apply to industrial life insurance, group life insurance, disability insurance, reinsurance, or annuities or to a provision in a life insurance policy relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(4) This section does not prohibit a provision that in the opinion of the commissioner is more favorable to the policyholder than a provision permitted by this section.

History: En. Sec. 320, Ch. 286, L. 1959; R.C.M. 1947, 40-3826; amd. Sec. 28, Ch. 198, L. 1979; amd. Sec. 7, Ch. 699, L. 1991; amd. Sec. 23, Ch. 451, L. 1993; amd. Sec. 6, Ch. 490, L. 1997; amd. Sec. 38, Ch. 472, L. 1999.

Cross-References

Contracts that violate policy of law — exemption from responsibility, 28-2-702.

33-20-122. Prohibited provisions — industrial life insurance. No policy of industrial life insurance shall contain any of the following provisions:

(1) a provision by which the insurer may deny liability under the policy for the reason that the insured has previously obtained other insurance from the same insurer;

(2) a provision giving the insurer the right to declare the policy void because the insured has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical, or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured has, within 2 years prior

to the issuance of the policy, received institutional, hospital, medical, or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning such treatment or attention was not of a serious nature or was not material to the risk;

(3) a provision giving the insurer the right to declare the policy void because the insured has been rejected for insurance, unless such right be conditioned upon a showing by the insurer that knowledge of such rejection would have led to a refusal by the insurer to make such contract.

History: **En. Sec. 321, Ch. 286, L. 1959; R.C.M. 1947, 40-3827.**

Cross-References

Contracts that violate policy of law — exemption from responsibility, 28-2-702.

33-20-123. Prohibited policy plans — life insurance policies or annuity contracts. (1) No insurer shall issue for delivery or deliver in this state any life insurance policy or annuity contract issued under any plan for the segregation of policyholders into mathematical groups and providing benefits for a surviving policyholder of a group arising out of the death of another policyholder of such group or under any other similar plan.

(2) No insurer shall issue for delivery or deliver in this state any life insurance policy or annuity contract providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination of the policies of other policyholders, whether by death or otherwise. This provision shall not be deemed to prohibit the payment or allowance of regular annual dividends or "savings" under participating forms of policies or contracts or prohibit the annual distribution to policyholders or beneficiaries of sums representing in part gains to the insurer from lapses, surrenders, or mortality either in general or as resulting from particular classifications of policies.

History: **En. Sec. 327, Ch. 286, L. 1959; R.C.M. 1947, 40-3833.**

Cross-References

Contracts that violate policy of law — exemption from responsibility, 28-2-702.

33-20-124. Policy provisions — conformity with state statutes. Each policy regulated by this part must contain a provision or the equivalent thereto as follows:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

History: **En. Sec. 22, Ch. 798, L. 1991.**

33-20-125 and 33-20-126 reserved.

33-20-127. Life insurance policy with long-term care provision or accelerated benefits provision — summary required. At the time of policy delivery, a summary must be delivered to the insured for an individual life insurance policy that provides accelerated benefits within the policy or by rider. An individual life insurance policy that provides long-term care benefits must provide a summary as described in 33-22-1123. In the case of direct response solicitations, the insurer shall deliver the summary upon the applicant's request but not later than the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include:

(1) an explanation of how the long-term care benefits or accelerated benefits interact with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits, if any, for each covered person;

(3) any exclusions, reductions, and limitations of long-term care benefits and accelerated benefits; and

(4) if applicable to the policy type:

(a) a disclosure of the effects of exercising other rights under the policy;

(b) a disclosure of guaranties related to long-term care costs of insurance charges; and

(c) current and projected maximum lifetime benefits.

History: **En. Sec. 3, Ch. 152, L. 1991; amd. Sec. 24, Ch. 451, L. 1993; amd. Sec. 1, Ch. 32, L. 2007.**

33-20-128. Life insurance policy paying long-term benefits — monthly report. When a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report must be provided to the policyholder as provided for in 33-22-1123 and this section. The report must include the following information for the month for which the report is issued:

(1) the amount of long-term care benefits paid out during the month;

(2) an explanation of any changes in the policy, including without limitation death benefits or cash values, resulting from long-term care benefits having been paid out; and

(3) the amount of long-term care benefits existing or remaining.

History: En. Sec. 4, Ch. 152, L. 1991; amd. Sec. 2, Ch. 416, L. 1997; amd. Sec. 2, Ch. 32, L. 2007.

33-20-129 and 33-20-130 reserved.

33-20-131. Policy loan or certificate loan. (1) Subject to the provisions of 33-20-101(2) and except as provided in 33-20-132 through 33-20-136, there must be a provision that after 3 full years' premiums have been paid and after the policy or certificate has a cash surrender value and while a premium is not in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy or certificate and on the sole security of the policy or certificate, at a specified rate of interest not exceeding 6% a year, an amount equal to or, at the option of the party entitled to the loan, less than the loan value of the policy or certificate. The commissioner may authorize a rate of interest in excess of 6%, but not in excess of 8% a year (or 7.4% if payable annually in advance), for policies or certificates issued on or after January 1, 1980, if the insurer provides adequate written certification that the holders of the policies will benefit fully from the increased earnings of the insurer resulting from the use of an interest rate in excess of the 6% per annum, such as from higher interest income to the company on policy or certificate loans, higher investment yield resulting from a reduction in policy or certificate loans because of the higher policy or certificate loan interest rate, and any additional income to the company resulting from the use of the higher interest rate in any manner. These benefits to the policyholder must be reflected through higher dividends, lower premiums, or both. The loan value of the policy must be at least equal to the cash surrender value at the end of the then current policy or certificate year, provided that the insurer may deduct, either from the loan value or from the proceeds of the loan, any existing indebtedness not already deducted in determining the cash surrender value (including interest then accrued but not due), an unpaid balance of the premium for the current policy or certificate year, and interest on the loan to the end of the current policy or certificate year unless the policyowner by written notice to the insurer elects to defer payment of interest until it has accrued. The policy or certificate may also provide that if interest on indebtedness is not paid when due, it must be added to the existing indebtedness and must bear interest at the same rate, and that if and when the total indebtedness on the policy or certificate, including interest due or accrued, equals or exceeds the amount of its loan value, the policy or certificate terminates and is void. The policy or certificate must reserve to the insurer the right to defer the granting of a loan, other than for the payment of a premium to the insurer, for 6 months after application for the loan. The policy or certificate, at the insurer's option, may provide for an automatic premium loan, subject to an election of the party entitled to elect.

(2) This section does not apply to term policies or to term insurance benefits provided by rider or supplemental policy provisions or to industrial life insurance policies.

History: En. Sec. 303, Ch. 286, L. 1959; R.C.M. 1947, 40-3809; amd. Sec. 1, Ch. 179, L. 1979; amd. Sec. 6, Ch. 191, L. 1985; Sec. 33-20-109, MCA 1983; redes. 33-20-131 by Code Commissioner, 1985; amd. Sec. 8, Ch. 699, L. 1991.

33-20-132. Variable policy loan interest rates — purpose. The purpose of 33-20-132 through 33-20-136 is to permit and set guidelines for life insurers to include in life insurance policies issued after October 1, 1985, a provision for periodic adjustment of policy loan interest rates.

History: En. Sec. 1, Ch. 191, L. 1985.

33-20-133. Variable interest rates — exclusions from application. The provisions of 33-20-132 through 33-20-136 do not apply to:

(1) term policies;

(2) term insurance benefits provided by rider or supplemental policy provisions; or

(3) industrial life insurance policies except as provided in 33-20-112.

History: En. Sec. 2, Ch. 191, L. 1985.

33-20-134. Variable interest rates — published monthly average defined. For purposes of 33-20-132 through 33-20-136, the "published monthly average" means:

(1) Moody's corporate bond yield average—monthly average corporates, as published by Moody's investors service, incorporated; or

(2) in the event that Moody's corporate bond yield average—monthly average corporates is no longer published, a substantially similar average, established by rule of the commissioner.

History: **En. Sec. 3, Ch. 191, L. 1985.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-20-135. Variable interest rates on policy loans. (1) (a) Life insurance policies issued on or after October 1, 1985, may have a provision permitting policy loan interest rates as follows:

(i) a maximum interest rate of not more than 8% a year; or

(ii) an adjustable maximum interest rate established from time to time by the life insurer as permitted by 33-20-132 through 33-20-136.

(b) A life insurer is not permitted to issue policies containing variable rates of interest on policy loans under subsection (1)(a)(ii) unless the insurer also makes available policies, which may or may not be on the same plan of insurance, with fixed rates of interest on policy loans under subsection (1)(a)(i).

(2) The rate of interest charged on a policy loan made under subsection (1)(a)(ii) may not exceed the greater of:

(a) the published monthly average for the calendar month ending 2 months before the date on which the rate is determined; or

(b) the rate used to compute the cash surrender values under the policy during the applicable period plus 1% a year.

(3) If the maximum rate of interest is determined pursuant to subsection (1)(a)(ii), the policy must contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(4) The maximum rate for each policy must be determined at regular intervals that must occur at least once every 12 months, but may not occur more frequently than once in any 3-month period. At the intervals specified in the policy, the rate being charged:

(a) may be increased whenever an increase as determined under subsection (2) would increase the rate by 0.5% or more a year;

(b) must be reduced whenever a reduction as determined under subsection (2) would decrease the rate by 0.5% or more a year.

(5) The life insurer shall:

(a) notify the policyholder of the initial rate of interest on the loan at the time a cash loan is made;

(b) notify the policyholder, with respect to premium loans, of the initial rate of interest on the loan as soon as practical after making the initial loan. Notice does not have to be given to the policyholder when a further premium loan is added, except as provided in subsection (5)(c).

(c) send reasonable advance notice of any increase in the rate to policyholders with loans; and

(d) include in the notices required by this subsection (5) the substance of subsection (1) and the frequency of rate determinations as provided in subsection (3).

(6) The policy may provide that if interest on any indebtedness is not paid when due, the interest will be added to the existing indebtedness and will bear interest at the same rate as the indebtedness.

(7) The loan value of the policy must be determined in accordance with the provisions of 33-20-131, but no policy may be terminated in a policy year solely as a result of a change in the interest rate during that policy year. The life insurer shall maintain coverage during that policy year until the time at which the policy would otherwise have terminated if there had been no interest rate change during that policy year.

(8) The substance of the pertinent provisions of subsections (1) and (3) must be set forth in the policies to which they apply.

(9) For purposes of this section, the following definitions apply:

(a) "Policy" includes certificates issued by a fraternal benefit society and annuity contracts that provide for policy loans.

(b) "Policy loan" includes any premium loan made under a policy used to pay one or more premiums that were not paid to the life insurer as they became due. The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after the lapse of a policy.

(c) "Policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

(10) No other provision of law applies to policy loan interest rates unless it is made specifically applicable to such rates.

History: **En. Sec. 4, Ch. 191, L. 1985.**

33-20-136. Variable interest rates — applicability to policies issued before October 1985. The provisions of 33-20-132 through 33-20-135 do not apply to any insurance contract issued before October 1, 1985, unless the policyholder agrees in writing to the applicability of such provisions.

History: **En. Sec. 5, Ch. 191, L. 1985.**

33-20-137 through 33-20-140 reserved.

33-20-141. Notice required for cancellation. (1) Subject to subsection (2), an insurer may not cancel a life insurance policy or annuity for nonpayment of premiums until the insurer has mailed or delivered to the named insured and policyowner, where they are not the same, at the last-known post office address shown in the records of the company one written notice of cancellation in addition to any billing statement, stating the date the cancellation will become effective, which may not be less than 30 days after the date of mailing or delivery of the notice. Said 30 days shall run concurrently with the grace period required by 33-20-104.

(2) (a) An insurer that delivers or issues for delivery an individual life insurance policy in this state shall notify an applicant in writing at the time of application for the policy of the applicant's right to designate a third party to receive notice of cancellation of the policy based on nonpayment of premium. The applicant may make the designation at the time of application for the policy or at any time the policy is in force by submitting a written notice to the insurer containing the name and address of the third-party designee.

(b) The insurer's transmission to the third-party designee of a copy of a notice of cancellation based on nonpayment of premium must be in addition to the transmission of the original document to the policyowner. The copy of the notice of cancellation transmitted to the third party must be governed by the same law and policy provisions that govern the notice being transmitted to the policyowner.

(c) The designation of a third party may not constitute acceptance of any liability on the part of the third party or insurer for services provided to the policyowner.

History: **En. Sec. 1, Ch. 723, L. 1985; amd. Sec. 2, Ch. 324, L. 2017.**

33-20-142. Contents of notice — proof — limitation on recovery — exemptions. (1) (a) The notice of cancellation shall state:

(i) the amount of the premium, installment, or interest due on such policy;

(ii) the place where it must be paid; and

(iii) the name and address of the person or company to which the premium is payable.

(b) The notice must also state that unless the premium or other sums are paid to the company or its insurance producer, the policy will lapse or be forfeited, except as to any nonforfeiture options provided for by a life insurance policy.

(2) "Policyowner", as used in this section, means the owner of the policy or any other person designated as the person to receive premium notices, as shown by the records of the insurance company.

(3) The affidavit of any responsible officer, clerk, or insurance producer of the insurance company authorized to mail the notice that it is the standard practice of the company to mail to policyowners the notice required by this section is prima facie evidence that the notice has been duly given.

(4) No action may be maintained to recover under a lapsed or forfeited policy on the ground that the insurance company failed to comply with this section unless the action is instituted within 2 years from the due date upon which default was made in paying the premium, installment, or interest for which lapse or forfeiture is claimed.

(5) Section 33-20-141 does not apply to:

(a) group or group-type policies;

(b) industrial life or industrial disability policies; or

(c) policies upon which premiums are payable monthly or at more frequent intervals.

History: **En. Sec. 2, Ch. 723, L. 1985; amd. Sec. 1, Ch. 713, L. 1989.**

33-20-143 through 33-20-149 reserved.

33-20-150. Life insurance policy and sales illustrations — annuity disclosure — rules. (1) (a) The commissioner shall adopt rules providing for and regulating life insurance policy illustrations, annuity disclosure, and sales illustrations that are marketed, issued, or issued for delivery to Montana residents.

(b) The rules must specify any types of life insurance or annuities that are exempt from the provisions of the rules.

(2) The rules must be designed to:

(a) protect life insurance and annuity consumers;

(b) foster consumer education;

(c) improve consumers' ability to understand the basic features of life insurance policies and annuities; and

(d) improve consumers' ability to select the most appropriate plan of life insurance or annuity.

(3) Rules that are adopted by the commissioner may not go beyond the scope of, or contain material differences from, the national association of insurance commissioners' life insurance illustrations, annuity disclosure, and sales model regulations.

(4) After the effective date of rules that are adopted pursuant to this section, a group or individual life insurance policy, certificate, or annuity may not be marketed, issued, or issued for delivery to a Montana resident unless the policy, certificate, or annuity conforms to the rules that are adopted pursuant to this section.

History: **En. Sec. 1, Ch. 76, L. 1999.**

33-20-151. Repealed. Sec. 134, Ch. 494, L. 1993.

History: **En. Sec. 30, Ch. 582, L. 1989.**

Part 2
Standard Nonforfeiture Law
Life Insurance

Part Cross-References

Nonforfeiture rights — applicable to policies issued prior to operative date, 33-20-117.

33-20-201. Short title. This part shall be known as the "Standard Nonforfeiture Law for Life Insurance".

History: **En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(1); amd. Sec. 5, Ch. 346, L. 1979.**

33-20-202. Nonforfeiture provisions. (1) In the case of policies issued on or after the operative date of this part as defined in 33-20-213, no policy of life insurance, except as set forth in 33-20-212, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this section and are essentially in compliance with 33-20-210:

(a) that in the event of default in any premium payment after premiums have been paid for at least 1 full year, the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be specified in this part. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit that provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(b) that upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least 3 full years in the case of ordinary insurance and 5 full years in the case of industrial insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be specified in this part;

(c) that a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default;

(d) that if the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the insurer will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of such amount as may be specified in this part;

(e) for a policy that has on a basis guaranteed in the policy unscheduled changes in benefits or premiums or that provides an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. For each other policy a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary, either during the first 20 policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy.

(f) a statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of this state;

(g) an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy;

(h) if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and

(i) a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

(2) Any of the provisions or portions thereof set forth in subsections (1)(a) through (1)(i) which are not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy. The insurer shall reserve the right to defer the payment of any cash surrender value for a period of 6 months after demand therefor with surrender of the policy.

History: En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(2), (3); amd. Sec. 1, Ch. 498, L. 1983.

33-20-203. Cash surrender value — paid-up nonforfeiture benefit — life. (1) Except as provided in subsection (2), any cash surrender value available under the policy in the event of default in the premium payment due on any policy anniversary, whether or not required by 33-20-202, is an amount not less than the excess, if any, of the present value on the anniversary of the future guaranteed benefits that would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(a) the then present value of the adjusted premiums as defined in 33-20-204 through 33-20-208 corresponding to premiums that would have fallen due on and after the anniversary; and

(b) the amount of any indebtedness to the insurer on account of or secured by the policy.

(2) For any policy issued on or after the relevant operative date of 33-20-208 that provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in subsection (1) is an amount not less than the sum of the cash surrender value as defined in subsection (1) for an otherwise similar policy issued at the same age without a rider or a supplemental policy provision and the cash surrender value as defined in subsection (1) for a policy that provides only the benefits otherwise provided by the rider or the supplemental policy provision.

(3) Any cash surrender value available within 30 days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefits, whether or not required by 33-20-202, is an amount not less than the present value, on the anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on account of or secured by the policy.

(4) Any paid-up nonforfeiture benefit available under the policy in the event of default in the premium payment due on any policy anniversary is its present value as of the anniversary to the extent that the nonforfeiture benefit is at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value that would have been required by this part in the absence of the conditions that premiums must have been paid for at least a specified period.

(5) For any family policy issued on or after the relevant operative date of 33-20-208 that defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse reaches 71 years of age, the cash surrender value referred to in subsection (1) is an amount not less than the sum of the cash surrender value as defined in subsection (1) for an otherwise similar policy issued at the same age without the term insurance on the life of the spouse and the cash surrender value as defined in subsection (1) for a policy that provides only the benefits otherwise provided by the term insurance on the life of the spouse.

History: En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(4), (5); amd. Sec. 2, Ch. 498, L. 1983; amd. Sec. 37, Ch. 370, L. 2015.

33-20-204. Adjusted premium. (1) This section does not apply to policies issued on or after the operative date of 33-20-208.

(2) (a) Except as provided in subsection (3), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding extra premiums on a substandard policy, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(i) the then present value of the future guaranteed benefits provided for by the policy;

(ii) 2% of the amount of the insurance if the insurance be uniform in amount or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with the duration of the policy;

(iii) 40% of the adjusted premium for the first policy year;

(iv) 25% of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

(b) In applying the percentages specified in subsections (iii) and (iv) above, no adjusted premiums shall be deemed to exceed 4% of the amount of insurance or uniform amount equivalent thereto.

(c) Whenever the plan or term of a policy has been changed, either by request of the insured or automatically in accordance with the provisions of the policy, the date of inception of the changed policy for the purposes of determining a nonforfeiture benefit or cash surrender value shall be the date as of which the age of the insured is determined for the purposes of the changed policy. The date of issue of a policy for the purposes of this subsection shall be the date as of which the rated age of the insured is determined.

(d) (i) In the case of a policy providing an amount of insurance varying with the duration of the policy, the equivalent uniform amount thereof for the purpose of the preceding subsections

(a) and (b) shall be deemed to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy.

(ii) In the case of a policy for a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age 10 were the amount provided by such policy at age 10.

(3) (a) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (i) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (ii) the adjusted premiums for such term insurance.

(b) The foregoing items (a)(i) and (a)(ii) being calculated separately and as specified in subsection (2) except that, for the purposes of (ii), (iii), and (iv) of subsection (2), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (a)(ii) of this subsection shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a)(i) of this subsection.

History: **En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(6), (7), (7-a); amd. Sec. 3, Ch. 498, L. 1983.**

33-20-205. Calculation — mortality table — rates of interest. Except as otherwise provided in 33-20-206 and 33-20-207:

(1) All adjusted premiums and present values referred to in this part shall for all policies of ordinary insurance be calculated on the basis of the commissioner's 1941 standard ordinary mortality table.

(2) For any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated, at the option of the insurer with approval of the commissioner, according to an age younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 standard industrial mortality table.

(3) All calculations shall be made on the basis of the rate of interest, not exceeding 3½% per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits.

(4) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130% of the rates of mortality according to such applicable table.

(5) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the commissioner.

History: **En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(8).**

33-20-206. Mortality tables — policies issued after operative date. (1) This section does not apply to ordinary policies issued on or after the operative date of 33-20-208.

(2) In the case of ordinary policies issued on or after the operative date of this section as defined herein, all adjusted premiums and present values referred to in this part shall be calculated on the basis of the commissioner's 1958 standard ordinary mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that:

(a) such rate of interest shall not exceed 3½% per annum, except that a rate of interest not exceeding 4% per annum may be used for policies issued on or after March 17, 1973, and prior to July 1, 1979, and a rate of interest not exceeding 5½% a year may be used for policies issued on or after July 1, 1979;

(b) for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than 6 years younger than the actual age of the insured;

(c) in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1958 extended term insurance table;

(d) for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(3) After July 1, 1961, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of this section for such insurer), this section shall become operative with respect to the ordinary policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this section for such insurer shall be January 1, 1966.

History: En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(8-a); amd. Sec. 6, Ch. 346, L. 1979; amd. Sec. 4, Ch. 498, L. 1983.

33-20-207. Industrial policies — mortality tables. (1) This section does not apply to industrial policies issued on or after the operative date of 33-20-208.

(2) In the case of industrial policies issued on or after the operative date of this section as defined herein, all adjusted premiums and present values referred to in this part shall be calculated on the basis of commissioner's 1961 standard industrial mortality table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that:

(a) such rate of interest shall not exceed 3½% per annum except that a rate of interest not exceeding 4% per annum may be used for policies issued on or after March 17, 1973, and prior to July 1, 1979, and a rate of interest not exceeding 5½% a year may be used for policies issued on or after July 1, 1979;

(b) in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1961 industrial extended term insurance table;

(c) for insurance issued on a substandard basis the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(3) After February 22, 1965, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of this section for such insurer), this section shall become operative with respect to the industrial policies thereafter issued by such insurer. If an insurer makes no such election, the operative date of this section for such insurer shall be January 1, 1968.

History: En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(8-b); amd. Sec. 7, Ch. 346, L. 1979; amd. Sec. 5, Ch. 498, L. 1983.

33-20-208. Mortality tables — interest rate adjusted premiums. (1) (a) This section applies to all policies issued on or after the operative date of this section. Except as provided in subsection (7), the adjusted premiums for any policy are calculated on an annual basis and must be a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments, special hazards, and any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits. The uniform percentage must represent the present value, at the date of issue of the policy, of all adjusted premiums that is equal to the sum of:

(i) the then present value of the future guaranteed benefits provided for by the policy;

(ii) 1% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

(iii) 125% of the nonforfeiture net level premium as provided in subsection (2). A nonforfeiture net level premium is considered not to exceed 4% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years.

(b) The date of issue of a policy for the purpose of this subsection is the date as of which the rated age of the insured is determined.

(2) The nonforfeiture net level premium is equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of that policy on which a premium falls due.

(3) For policies that have on a basis guaranteed in the policy unscheduled changes in benefits or premiums or that provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values are initially calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any change in the benefits or premiums, the future adjusted premiums, nonforfeiture net level premiums, and present values must be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(4) Except as otherwise provided in subsection (7), the recalculated future adjusted premiums for any policy are a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments, special hazards, and any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits. The uniform percentage must be the present value, at the time of change to the newly defined benefits or premiums, of all future adjusted premiums that is equal to the excess of:

(a) the sum of:

(i) the then present value of the then future guaranteed benefits provided for by the policy; and

(ii) the additional expense allowance, if any; over

(b) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(5) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, is the sum of:

(a) 1% of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years subsequent to the change, over the average amount of insurance prior to the change at the beginning of each of the first 10 policy years subsequent to the time of the most recent previous change or, if there has been no previous change, the date of issue of the policy; and

(b) 125% of the increase, if positive, in the nonforfeiture net level premium.

(6) The recalculated nonforfeiture net level premium is equal to the result obtained by dividing the product of subsection (a) by the product of subsection (b):

(a) (i) the nonforfeiture net level premium applicable prior to the change multiplied by the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(ii) the present value of the increase in future guaranteed benefits provided for by the policy;

(b) the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(7) Adjusted premiums and present values for a substandard policy may be calculated as if the substandard policy were issued to provide higher uniform amounts of insurance on the standard basis, regardless of other provisions of this section for a policy issued on a substandard basis that provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis that provides higher uniform amounts of insurance.

(8) Except as provided below, all adjusted premiums and present values referred to in this part are for policies of ordinary insurance calculated on the basis of the commissioner's 1980 standard ordinary mortality table or, at the election of the insurer for any one or more specified plans of life insurance, the commissioner's 1980 standard ordinary mortality table with 10-year

select mortality factors. All adjusted premiums and present values for policies of industrial insurance are calculated on the basis of the commissioner's 1961 standard industrial mortality table. All adjusted premiums and present values for all policies issued in a particular calendar year are calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as provided in this subsection for policies issued in that calendar year; with the following exceptions and conditions:

(a) At the option of the insurer, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as provided in this subsection for policies issued in the immediately preceding calendar year.

(b) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by 33-20-202, is calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(c) An insurer may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions under the policy, on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioner's 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioner's 1961 industrial extended term insurance table for policies of industrial insurance.

(e) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on appropriate modifications of the tables set forth in this subsection (8).

(f) (i) For policies issued prior to the operative date of the valuation manual as provided in 33-2-409, any commissioner's standard ordinary mortality tables adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1980 standard ordinary mortality table with or without 10-year select mortality factors or for the commissioner's 1980 extended term insurance table.

(ii) For policies issued on or after the operative date of the valuation manual as provided in 33-2-409, the commissioner may use the standard mortality table provided in the valuation manual for use in determining the minimum nonforfeiture standard instead of using either the commissioner's 1980 standard ordinary mortality table with or without 10-year select mortality factors or the commissioner's 1980 extended term insurance table.

(iii) A minimum nonforfeiture standard, if adopted by the commissioner by rule for the commissioner's standard mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, supersedes the valuation manual's nonforfeiture standard.

(g) (i) For policies issued prior to the operative date of the valuation manual, any industrial mortality tables adopted after 1980 by the national association of insurance commissioners that are approved by the commissioner by rule for use in determining the minimum nonforfeiture standard may be substituted for the commissioner's 1961 standard industrial mortality table or the commissioner's 1961 industrial extended term insurance table.

(ii) For policies issued on or after the operative date of the valuation manual, the valuation manual must provide the commissioner's standard mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the commissioner's 1961 standard industrial mortality table or the commissioner's 1961 industrial extended term insurance table.

(iii) A minimum nonforfeiture standard, if adopted by the commissioner by rule for the commissioner's standard industrial mortality table adopted by the national association of insurance commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, supersedes the valuation manual's nonforfeiture standard.

(9) (a) For policies issued prior to the operative date of the valuation manual, the annual nonforfeiture interest rate for any policy issued in a particular calendar year must be equal to

125% of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law, Title 33, chapter 2, part 5, rounded to the nearer 1/4 of 1%. However, the nonforfeiture interest rate provided for in this subsection (9)(a) may not be less than 4.00%.

(b) For policies issued on or after the operative date of the valuation manual, the annual nonforfeiture interest rate for any policy issued in a particular calendar year must be as provided in the valuation manual.

(10) Any refiling of nonforfeiture values or their methods of computation for any previously approved policy form that involves only a change in the interest rate or mortality table used to compute nonforfeiture values does not require refiling of any other provisions of that policy form.

(11) After October 1, 1983, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date, before January 1, 1989, which is the operative date of this section for that insurer. If an insurer makes no election, the operative date of this section for the insurer is January 1, 1989.

History: **En. Sec. 6, Ch. 498, L. 1983; amd. Sec. 38, Ch. 370, L. 2015.**

33-20-209. Determination of nonforfeiture values for special plans. For a plan of life insurance that provides for future premium determination the amounts of which are to be determined by the insurer based on then estimates of future experience or for a plan of life insurance that is of such a nature that minimum values cannot be determined by the methods described in 33-20-204 through 33-20-208:

(1) the commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by 33-20-204 through 33-20-208;

(2) the commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(3) the cash surrender values and paid-up nonforfeiture benefits provided by such plan may not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this part, as determined by rules promulgated by the commissioner.

History: **En. Sec. 7, Ch. 498, L. 1983.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-20-210. Additional rules for calculating cash surrender values. (1) This section, in addition to all other applicable sections of this chapter, applies to all policies issued on or after January 1, 1987. Any cash surrender value available under the policy upon default in a premium payment due on any policy anniversary is an amount that does not differ by more than 2/10 of 1% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years subtracted from the sum of:

(a) the greater of zero and the basic cash value specified in subsection (2); and

(b) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy.

(2) The basic cash value is equal to the present value, on such anniversary, of the future guaranteed benefits that would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, if there had been no default less the then present value of the nonforfeiture factors, as provided in subsection (3), corresponding to premiums that would have fallen due on and after such anniversary date. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in 33-20-203 or 33-20-204, whichever is applicable, are the same as the effects specified in 33-20-203 or 33-20-204, whichever is applicable, on the cash surrender values defined in that section.

(3) The nonforfeiture factor for each policy year is an amount equal to a percentage of the adjusted premium for the policy year, as defined in 33-20-204 or 33-20-208, whichever is applicable. Except as is required by subsection (4), the percentage:

(a) must be the same percentage for each policy year between the second policy anniversary date and the later of the fifth policy anniversary date and the first policy anniversary date at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least 2/10 of 1% of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

(b) must be such that no percentage after the later of the two policy anniversary dates specified in subsection (3)(a) applies to less than 5 consecutive policy years.

(4) No basic cash value may be less than the value that would be obtained if the adjusted premiums for the policy, as provided in 33-20-204 or 33-20-208, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

(5) Adjusted premiums and present values referred to in this section must, for a particular policy, be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other sections of this part. The cash surrender values referred to in this section include any endowment benefits provided for by the policy.

(6) A cash surrender value available other than upon default in a premium payment due on a policy anniversary date and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment are determined consistently with provisions specified for determining the analogous minimum amounts in 33-20-202 through 33-20-204, 33-20-208, and 33-20-211. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed in 33-20-211(4) must conform with the principles of this section.

History: En. Sec. 9, Ch. 498, L. 1983.

33-20-211. Calculation of values — other requisites. (1) Any cash surrender value and any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary.

(2) All values referred to in 33-20-203 through 33-20-208 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death.

(3) The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to provide such additions.

(4) Notwithstanding the provisions of subsections (1) and (3) of 33-20-203, additional benefits payable under the following circumstances shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this part, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits:

(a) in the event of death or dismemberment by accident or accidental means;

(b) in the event of total and permanent disability;

(c) as reversionary annuity or deferred reversionary annuity benefits;

(d) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this part would not apply;

(e) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, is uniform in amount after the child's age is 1, and has not become paid up by reason of the death of a parent of the child; and

(f) as other policy benefits additional to life insurance and endowment benefits and premiums for all such additional benefits.

History: En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(9); amd. Sec. 8, Ch. 498, L. 1983.

33-20-212. Exceptions. (1) This part does not apply to:

(a) reinsurance;

(b) group insurance;

(c) a pure endowment;

(d) an annuity or reversionary annuity contract;

(e) a term policy of uniform amount that provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less expiring before age 71 for which uniform premiums are payable during the entire term of the policy;

(f) a term policy of decreasing amount that provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in 33-20-204 through 33-20-208, is less than the adjusted premiums so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(g) a policy which provides no guaranteed nonforfeiture or endowment benefits for which the cash surrender value, if any, or present value of any paid-up nonforfeiture benefit at the beginning of any policy year, calculated as specified in 33-20-203 through 33-20-208, does not exceed 2.5% of the amount of insurance at the beginning of the same policy year;

(h) a policy that is delivered outside this state through an insurance producer or other representative of the insurer issuing the policy.

(2) For purposes of subsection (1), the age at expiry for a joint term life insurance policy is the age at expiry of the oldest life.

History: En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(10); amd. Sec. 10, Ch. 498, L. 1983; amd. Sec. 1, Ch. 713, L. 1989.

33-20-213. Operative date. After July 1, 1945, any insurer could have filed with the state auditor a written notice of its election to comply with the provisions of this part, except 33-20-206 and 33-20-207, after a specified date before January 1, 1948, with respect to the policies specified in the notice. After the filing of such notice, then upon such specified date (which shall be the operative date for such insurer with respect to such policies), this part, except 33-20-206 and 33-20-207, shall have become operative with respect to the policies specified in such notice thereafter issued by such insurer. As to all of its policies and contracts with respect to which an insurer makes no such election, the operative date of this part, except 33-20-206 and 33-20-207, with respect to such policies and contracts for such insurer is January 1, 1948.

History: En. Sec. 325, Ch. 286, L. 1959; amd. Sec. 1, Ch. 65, L. 1961; amd. Sec. 1, Ch. 42, L. 1965; amd. Sec. 2, Ch. 341, L. 1973; R.C.M. 1947, 40-3831(11); amd. Sec. 24, Ch. 198, L. 1979.

Cross-References

Contracts prior to operative date, 33-2-408.
Contracts on or after certain operative dates, 33-2-409.

Part 3
Annuity Contract Provisions

33-20-301. Standard provisions — annuity and pure endowment contracts. (1) No annuity or pure endowment contract, other than reversionary annuities, survivorship annuities, or group annuities and except as stated herein, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in 33-20-302 through 33-20-307. Any of such provisions not applicable to single premium annuities or single premium pure endowment contracts shall not, to that extent, be incorporated therein.

(2) This section shall not apply to contracts for deferred annuities included in or upon the lives of beneficiaries under life insurance policies.

History: En. Sec. 312, Ch. 286, L. 1959; R.C.M. 1947, 40-3818.

33-20-302. Grace period. In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that there shall be a period of grace of 1 month, but not less than 30 days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding 6% per annum for the number of days of grace elapsing before such payment, during which period of grace the contract shall continue in full force; but in case a claim arises under the contract on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

History: En. Sec. 313, Ch. 286, L. 1959; R.C.M. 1947, 40-3819.

Cross-References

Computation of time — which days counted, 1-1-306.

33-20-303. Incontestability. If any statements other than those relating to age and identity are required as a condition to issuing an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, and subject to 33-20-305, there shall be a provision that the contract shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of 2 years from its date of issue, except for nonpayment of stipulated payments to the insurer; and at the option of the insurer such contract may also except any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means.

History: En. Sec. 314, Ch. 286, L. 1959; R.C.M. 1947, 40-3820; amd. Sec. 9, Ch. 798, L. 1991.

33-20-304. Entire contract. In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that the contract shall constitute the entire contract between the parties or, if a copy of the application is endorsed upon or attached to the contract when issued, a provision that the contract and the application therefor shall constitute the entire contract between the parties.

History: En. Sec. 315, Ch. 286, L. 1959; R.C.M. 1947, 40-3821.

Cross-References

Interpretation of instruments, Title 1, ch. 4, part 1.

Interpretation of written contracts — statute of frauds, Title 28, ch. 2, part 9.

33-20-305. Misstatement of age. In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that if the age of the person or persons upon whose life or lives the contract is made, or of any of them, has been misstated, the amount payable or benefits accruing under the contract shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age and that if the insurer shall make or has made any overpayment or overpayments on account of any such misstatement, the amount thereof, with interest at the rate to be specified in the contract but not exceeding 6% per annum, may be charged against the current or next succeeding payment or payments to be made by the insurer under the contract.

History: En. Sec. 316, Ch. 286, L. 1959; R.C.M. 1947, 40-3822; amd. Sec. 10, Ch. 798, L. 1991.

33-20-306. Dividends. If an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, is participating, there shall be a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

History: En. Sec. 317, Ch. 286, L. 1959; R.C.M. 1947, 40-3823.

33-20-307. Reinstatement. In an annuity or pure endowment contract, other than a reversionary, survivorship, or group annuity, there shall be a provision that the contract may be reinstated at any time within 1 year from the default in making stipulated payments to the insurer, unless the cash surrender value had been paid, but all overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding 6% per annum payable annually. In cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer.

History: En. Sec. 318, Ch. 286, L. 1959; R.C.M. 1947, 40-3824.

33-20-308. Annuity information. The commissioner shall promulgate rules prescribing information that must be delivered to prospective annuitants at the time of sale. The rules must address the following:

(1) the manner of delivery of the information;
(2) when the information must be delivered;
(3) by whom the information is to be delivered; and
(4) the contents of the information, including:
(a) the type of annuity being sold; and
(b) the settlement options available under the annuity contract.

History: En. Sec. 1, Ch. 260, L. 1997.

33-20-309. Annuity penalty — 10-year prohibition. (1) An annuity may not charge a surrender penalty on an annuity contract after 10 years from:

(a) the date of issuance; or

(b) for contracts for which the annuitant voluntarily deposits a separate premium that was not required under the annuity contract, the date of each separate annuity premium deposit. Within 10 years after the separate deposit, the insurer may charge a surrender penalty for that deposit.

(2) An insurer must provide written notice to the annuitant of any surrender penalty imposed under the contract, including subsequent notices if the annuitant voluntarily contributes separate premium deposits under subsection (1)(b).

(3) For purposes of this section, the term "surrender penalty" means a surrender penalty, fee, or charge for the early withdrawal of funds from an annuity contract or for the cancellation of the annuity contract.

(4) This section applies to any annuity contract, including but not limited to annuity contracts under Title 30, chapter 10.

History: **En. Sec. 1, Ch. 177, L. 2017.**

Part 4
Reversionary Annuity Contract Provisions

33-20-401. Standard provisions. (1) Except as stated herein, no contract for a reversionary annuity shall be delivered or issued for delivery in this state unless it contains in substance each of the following provisions:

(a) Any such reversionary annuity contract shall contain the provisions specified in 33-20-302 through 33-20-306, except that under 33-20-302 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment in lieu of providing for deduction of such payments from an amount payable upon settlement under the contract.

(b) In such reversionary annuity contracts there shall be a provision that the contract may be reinstated at any time within 3 years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer and upon condition that all overdue payments and any indebtedness to the insurer on account of the contract be paid or, within the limits permitted by the then cash values of the contract, reinstated, with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding 6% per annum compounded annually.

(2) This section shall not apply to group annuities or to annuities included in life insurance policies, and any of such provisions not applicable to single premium annuities shall not to that extent be incorporated therein.

History: **En. Sec. 319, Ch. 286, L. 1959; R.C.M. 1947, 40-3825.**

Part 5
Standard Nonforfeiture Law
Individual Deferred Annuities

33-20-501. Short title. This part shall be known as the "Standard Nonforfeiture Law for Individual Deferred Annuities".

History: **En. Sec. 8, Ch. 346, L. 1979.**

33-20-502. Application. This part does not apply to any reinsurance, group annuity purchased under a retirement plan, or plan of deferred compensation established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended, premium deposit fund, variable annuity, investment annuity, immediate annuity, any deferred annuity contract after annuity payments have commenced, or reversionary annuity or to any contract which is delivered outside this state through an insurance producer or other representative of the company issuing the contract.

History: **En. Sec. 9, Ch. 346, L. 1979; amd. Sec. 1, Ch. 713, L. 1989.**

33-20-503. Nonforfeiture provisions. In the case of contracts issued on or after the operative date of this part as defined in 33-20-513, no contract of annuity except as stated in 33-20-502 shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or corresponding provisions which in the opinion of the commissioner are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract:

(1) that upon cessation of payment of considerations under a contract the company will grant a paid-up annuity benefit on a plan stipulated in the contract of such value as is specified in 33-20-506 through 33-20-509 and 33-20-511;

(2) that if a contract provides for a lump-sum settlement at maturity or at any other time, than upon surrender of the contract at or prior to the commencement of any annuity payments, the company will pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in 33-20-506, 33-20-507, 33-20-509, and 33-20-511. The company shall reserve the right to defer the payment of such cash surrender benefit for a period of 6 months after demand therefor with surrender of the contract.

(3) a statement of the mortality table, if any, and interest rates used in calculating any minimum paid-up annuity, cash surrender, or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of such benefits;

(4) a statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the company to the contract, any indebtedness to the company on the contract, or any prior withdrawals from or partial surrenders of the contract.

History: **En. Sec. 10, Ch. 346, L. 1979.**

33-20-504. Exception. Notwithstanding the requirements of 33-20-503, any deferred annuity contract may provide that if no consideration has been received under a contract for a period of 2 full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from consideration paid prior to such period would be less than $20 monthly, the company may at its option terminate such contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table, if any, and interest rate specified in the contract for determining the paid-up annuity benefit, and by such payment shall be relieved of any further obligation under such contract.

History: **En. Sec. 11, Ch. 346, L. 1979.**

33-20-505. Minimum nonforfeiture amounts. (1) The minimum values as specified in 33-20-506 through 33-20-509 and 33-20-511 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract must be based upon minimum nonforfeiture amounts, as defined in this section.

(2) (a) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments must be equal to an accumulation up to that time at rates of interest as indicated in subsection (3)(a) of the net considerations, as described in subsection (2)(b), paid prior to that time, decreased by the sum of:

(i) any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in subsection (3)(a);

(ii) an annual contract charge of $50 accumulated at rates of interest as indicated in subsection (3)(a);

(iii) any premium tax paid by the company for the contract accumulated at rates of interest as indicated in subsection (3)(a); and

(iv) the amount of any indebtedness to the company on the contract, including interest due and accrued.

(b) The net consideration for a given contract year used to define the minimum nonforfeiture amount must be an amount equal to 87.5% of the corresponding gross considerations credited to the contract during that contract year.

(3) (a) (i) The interest rate used in determining minimum nonforfeiture amounts must be an annual rate of interest determined as the lesser of 3% a year or the amount calculated under subsection (3)(a)(ii), which must be specified in the contract if the interest rate will be reset.

(ii) The interest rate may be the 5-year constant maturity treasury rate reported by the federal reserve board as of a date or an average over a period, rounded to the nearest 1/20th of 1%, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under subsection (3)(a)(iii) and reduced by 125 basis points whenever the resulting interest rate is not less than 0.15%.

(iii) The interest rate under subsection (3)(a)(ii) must apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, must be stated in the contract. The basis is the date or the average over a specified period that produces the value of the 5-year constant maturity treasury rate to be used at each redetermination date.

(b) During the period or term that a contract provides substantive participation in an equity indexed benefit, the contract may increase the reduction described in subsection (3)(a)(ii) by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date, of the additional reduction may not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. The commissioner may disallow or limit the additional reduction if the commissioner considers the demonstration unacceptable.

(4) The commissioner may adopt rules to implement the provisions of subsection (3)(b) and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts for which the commissioner determines that adjustments are justified.

History: En. Sec. 12, Ch. 346, L. 1979; amd. Sec. 1, Ch. 512, L. 2003; amd. Sec. 1, Ch. 66, L. 2005; amd. Sec. 4, Ch. 471, L. 2021.

33-20-506. Present value to equal minimum nonforfeiture amount. Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

History: En. Sec. 13, Ch. 346, L. 1979.

33-20-507. Cash surrender benefits. For contracts which provide cash surrender benefits, such cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid prior to the time of cash surrender reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing additional amounts credited by the company to the contract. No cash surrender benefit may be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

History: En. Sec. 14, Ch. 346, L. 1979.

33-20-508. Paid-up annuity benefits. For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity may not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for or changed to a deferred paid-up annuity, such present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine such maturity value and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, such present values shall be calculated on the basis of such interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. However, the present value of a paid-up annuity benefit may not be less than the minimum nonforfeiture amount at that time.

History: En. Sec. 15, Ch. 346, L. 1979.

33-20-509. Maturity date. For the purpose of determining the benefits calculated under 33-20-507 and 33-20-508, in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date is the latest date for which election is permitted by the contract but may not be later than the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, whichever is later.

History: En. Sec. 16, Ch. 346, L. 1979.

33-20-510. Statement of noninclusion of certain death benefits. Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement in a prominent place in the contract that such benefits are not provided.

History: En. Sec. 17, Ch. 346, L. 1979.

33-20-511. Adjusted benefit. Any paid-up annuity, cash surrender, or death benefits available at any time other than on the contract anniversary under any contract with fixed scheduled consideration shall be calculated with allowance for the lapse of time and the payment of any scheduled consideration beyond the beginning of the contract year in which cessation of payment of consideration under the contract occurs.

History: En. Sec. 18, Ch. 346, L. 1979.

33-20-512. Calculation of benefits — special benefits excluded. For any contract which provides, within the same contract by rider or supplemental contract provision, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross consideration paid with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding the provisions of 33-20-506 through 33-20-509 and 33-20-511, additional benefits payable in the event of total and permanent disability or as reversionary annuity or deferred reversionary annuity benefits or as other policy benefits additional to life insurance, endowment, and annuity benefits, and considerations for all such additional benefits shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender, and death benefits that may be required by this section. The inclusion of such additional benefits shall not be required in any paid-up benefits, unless such additional benefits separately would require minimum nonforfeiture amount paid-up annuity, cash surrender, and death benefits.

History: En. Sec. 19, Ch. 346, L. 1979.

33-20-513. Operative date. After July 1, 1979, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before July 1, 1981. After the filing of such notice, then upon such specified date, which shall be the operative date of this section for such company, this section shall become operative with respect to annuity contracts thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be July 1, 1981.

History: En. Sec. 20, Ch. 346, L. 1979.

Part 6
Variable Contracts

Part Cross-References

Contracts — generally, Title 28, ch. 2.
Interpretation of contracts, Title 28, ch. 3.
Domestic insurer — definition, 33-1-201.
Life insurance — definition, 33-1-208.

33-20-601. Short title. This part may be cited as the "Montana Variable Contract Law".

History: En. Sec. 1, Ch. 112, L. 1989.

33-20-602. Powers of commissioner. Except as provided in Title 30, chapter 10, parts 1 through 3, the commissioner has sole authority to regulate the issuance and sale of variable contracts and to adopt rules to carry out the purposes and provisions of this part.

History: En. Sec. 5, Ch. 112, L. 1989.

Cross-References
Adoption and publication of rules, Title 2, ch. 4, part 3.

33-20-603. Separate accounts for life insurance or annuities. (1) Subject to the provisions of subsection (2), a life insurer may establish one or more separate accounts and may allocate to those accounts the amounts necessary to provide for life insurance or annuities and benefits incidental to the life insurance or annuities, payable in fixed or variable amounts, or both. The amounts allocated to the accounts may include without limitation proceeds applied under optional modes of settlement or under dividend options.

(2) Separate accounts for life insurance or annuities established under the provisions of subsection (1) are subject to the following:

(a) The income, gains, and losses, realized or unrealized, from assets allocated to a separate account must be credited to or charged against the account, without regard to other income, gains, or losses of the insurer.

(b) Except as provided for reserves for guaranteed benefits and funds in subsection (2)(c):

(i) amounts allocated to a separate account and accumulations on the separate account may be invested and reinvested in any class of investment authorized under chapter 12 if limitations under 33-12-208 or 33-12-308 on investments in stocks are not applicable;

(ii) the investments in the separate account or accounts may not be considered in applying the investment limitations otherwise applicable to the investments of the insurer.

(c) Except with the approval of the commissioner and under conditions relating to investments and other prescribed matters that recognize the guaranteed nature of the benefits provided, reserves for benefits guaranteed as to amount and duration and for funds guaranteed as to principal amount or stated rate of interest may not be maintained in a separate account.

(d) Unless otherwise approved by the commissioner, assets allocated to a separate account must be valued at their market value on the date of valuation or, if there is no readily available market, as provided under the terms of the contract or the rules or other written agreement applicable to that separate account; however, unless otherwise approved by the commissioner, the portion, if any, of the assets of that separate account equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in subsection (2)(c) must be valued in accordance with the laws and rules otherwise applicable to the insurer's assets.

(e) Amounts allocated to a separate account in the exercise of the power granted by this part must be owned by the insurer, and the insurer may not be or hold itself out to be a trustee with respect to those amounts. If and to the extent provided under applicable contracts, that portion of the assets of a separate account equal to the reserves and other contract liabilities with respect to the account are not chargeable with liabilities arising out of any other business the insurer may conduct.

(f) (i) A sale, exchange, or other transfer of assets may not be made by an insurer between any of its separate accounts or between any other investment account and one or more of its separate accounts unless:

(A) in case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made; or

(B) the transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value and the transfer of securities is approved by the commissioner.

(ii) The commissioner may approve other transfers among these accounts if, in the commissioner's opinion, transfers would not be inequitable.

(g) To the extent an insurer considers it necessary to comply with any applicable federal or state laws, the insurer, with respect to any separate account, including without limitation any separate account that is a management investment company or a unit investment trust account, may provide, for persons having an interest in the account, appropriate voting and other rights and special procedures for the conduct of the business of that account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and selection of a committee, the members of which need not be otherwise affiliated with the insurer, to manage the business of that account.

History: En. Sec. 2, Ch. 112, L. 1989; amd. Sec. 25, Ch. 451, L. 1993; amd. Sec. 46, Ch. 304, L. 1999.

33-20-604. Contract to contain statement of essential features. A contract providing benefits payable in variable amounts delivered or issued for delivery in this state must contain a statement of the essential features of the procedures to be followed by the insurer in determining the dollar amount of the variable benefits. A contract under which the benefits vary to reflect investment experience, including a group contract and a certificate evidencing the variable benefits issued thereunder, must state that the dollar amount will vary and must contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

History: En. Sec. 3, Ch. 112, L. 1989.

Cross-References

Insurance contracts — generally, Title 33, ch. 15.

33-20-605. Requirements for doing business. (1) No insurer may deliver or issue for delivery within this state a variable contract unless the insurer is authorized to transact life insurance or annuity business in this state and the commissioner is satisfied that its condition or method of operation in connection with the issuance of variable contracts will not render its operation hazardous to the public or its policyholders in this state. In making such a determination, the commissioner must consider, among other things:

(a) the history and financial condition of the insurer;

(b) the character, responsibility, and fitness of the officers and directors of the insurer; and

(c) the laws and regulations under which the insurer is authorized in the state of domicile to issue variable contracts. For this purpose, the state of entry of an alien insurer is its place of domicile.

(2) The commissioner may consider an insurer to have met the provisions of this section if:

(a) the insurer is a subsidiary of an authorized life insurer or is affiliated with an authorized life insurer through common management or ownership; and

(b) either it, the parent, or the affiliated insurer meets the requirements of this section.

History: En. Sec. 4, Ch. 112, L. 1989.

33-20-606. Variable contracts to meet insurance contract requirements. (1) Except for 33-15-321 through 33-15-329, 33-20-302, and 33-20-307 for variable annuity contracts and 33-20-104, 33-20-110, 33-20-111, 33-20-112, and 33-20-201 through 33-20-213 for variable life insurance policies and as otherwise provided in this part, all pertinent provisions of Title 33 and other laws relating to insurance apply to separate accounts and their related policies and contracts.

(2) Any individual variable life insurance contract or any individual variable annuity contract delivered or issued for delivery in this state must contain grace and reinstatement provisions appropriate to the contract. Any individual variable life insurance contract must contain nonforfeiture provisions appropriate to that contract.

(3) A final prospectus must be dated and effective before an insurer issues or delivers an individual variable life insurance contract or an individual variable annuity contract in this state. The prospectus must be made available to the commissioner on request.

(4) The reserve liability for any variable contract must be established in accordance with actuarial procedures that recognize the variable nature of benefits provided and mortality guarantees.

History: En. Sec. 6, Ch. 112, L. 1989; amd. Sec. 19, Ch. 271, L. 2009; amd. Sec. 19, Ch. 157, L. 2023.

Part 7
Charitable Gift Annuities

33-20-701. Definitions. In this part, the following definitions apply:

(1) "Charitable gift annuity" means a transfer of cash or other property by a donor to a charitable organization in return for an annuity payable over one or two lives, for the duration of that life or those lives, under which the actuarial value of the annuity is less than the value of the cash or other property transferred and the difference in value constitutes a charitable deduction for federal tax purposes.

(2) "Charitable organization" means an entity described by:

(a) section 501(c)(3) of the Internal Revenue Code of 1986, 26 U.S.C. 501(c)(3); or

(b) section 170(c) of the Internal Revenue Code of 1986, 26 U.S.C. 170(c).

(3) (a) "Qualified charitable gift annuity" means a charitable gift annuity, described by section 501(m)(5) of the Internal Revenue Code of 1986, 26 U.S.C. 501(m)(5), section 514(c)(5) of the Internal Revenue Code of 1986, 26 U.S.C. 514(c)(5), section 1011(b) of the Internal Revenue Code of 1986, 26 U.S.C. 1011(b), and the implementing regulations, that is issued by a charitable organization that, on the date of the annuity agreement:

(i) has a minimum of $300,000 net worth or has a minimum of $100,000 in unrestricted cash, cash equivalents, or publicly traded securities, exclusive of the assets funding the annuity agreement;

(ii) has been in continuous operation for at least 3 years or is a successor or affiliate of a charitable organization that has been in continuous operation for at least 3 years; and

(iii) maintains a separate annuity fund with at least one-half the value of the initial amount transferred for outstanding annuities.

(b) If the charitable organization cannot meet the requirements of subsections (3)(a)(i) through (3)(a)(iii), the issuance of a qualified charitable gift annuity by a charitable organization must be commercially insured by a licensed insurance company that is qualified to do business in Montana.

History: **En. Sec. 1, Ch. 482, L. 2003.**

33-20-702. Charitable gift annuity not insurance. (1) The issuance of a qualified charitable gift annuity does not constitute engaging in the business of insurance in this state.

(2) A charitable gift annuity issued before April 24, 2003, is a qualified charitable gift annuity for purposes of this part, and the issuance of that charitable gift annuity does not constitute engaging in the business of insurance in this state.

History: **En. Sec. 2, Ch. 482, L. 2003.**

33-20-703. Repealed. Sec. 6, Ch. 26, L. 2019.

History: **En. Sec. 3, Ch. 482, L. 2003.**

33-20-704. Repealed. Sec. 6, Ch. 26, L. 2019.

History: **En. Sec. 4, Ch. 482, L. 2003; amd. Sec. 24, Ch. 469, L. 2005.**

33-20-705. Repealed. Sec. 6, Ch. 26, L. 2019.

History: **En. Sec. 5, Ch. 482, L. 2003.**

Part 8
Suitability in Annuity Transactions

33-20-801. Short title. This part may be referred to as the "Montana Suitability in Annuity Transactions Act".

History: **En. Sec. 1, Ch. 476, L. 2007.**

33-20-802. Purpose — scope. (1) The purpose of this part is to require producers to act in the best interest of the consumer when making a recommendation of an annuity and to require insurers to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of consumers at the time of the transaction are effectively addressed.

(2) This part applies to any sale or recommendation of an annuity.

(3) Nothing in this part may be construed to create or imply a private cause of action for a violation of this part or to subject a producer to civil liability under the best interest standard of care outlined in 33-20-805 or under standards governing the conduct of a fiduciary or a fiduciary relationship.

History: **En. Sec. 2, Ch. 476, L. 2007; amd. Sec. 3, Ch. 324, L. 2017; amd. Sec. 1, Ch. 432, L. 2021.**

33-20-803. Exemptions. Unless otherwise specifically included, this part does not apply to recommendations involving:

(1) direct response solicitations when there is no recommendation made based on information collected from the consumer pursuant to this part;

(2) contracts used to fund:

(a) an employee pension or welfare benefit plan that is covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.;

(b) a plan described by section 401(a), 401(k), 403(b), 408(k), or 408(p) of the Internal Revenue Code, 26 U.S.C. 401(a), 401(k), 403(b), 408(k), or 408(p), if established or maintained by an employer;

(c) a governmental plan or church plan defined in section 414 of the Internal Revenue Code, 26 U.S.C. 414, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under section 457 of the Internal Revenue Code, 26 U.S.C. 457;

(d) a nonqualified deferred compensation plan established or maintained by an employer or plan sponsor;

(3) settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process;

(4) formal prepaid funeral contracts; or

(5) variable annuities regulated under Title 30, chapter 10.

History: En. Sec. 3, Ch. 476, L. 2007; amd. Sec. 2, Ch. 432, L. 2021.

33-20-804. Definitions. As used in this part, the following definitions apply:

(1) "Annuity" means a fixed annuity that is individually solicited, regardless of whether the product is classified as an individual or group annuity.

(2) "Cash compensation" means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer, intermediary, or directly from the consumer.

(3) "Consumer profile information" means information that is reasonably appropriate to determine whether a recommendation addresses the consumer's financial situation, insurance needs, and financial objectives, including, at a minimum, the following:

(a) age;

(b) annual income;

(c) financial situation and needs, including debts and other obligations;

(d) financial experience;

(e) insurance needs;

(f) financial objectives;

(g) intended use of the annuity;

(h) financial time horizon;

(i) existing assets or financial products, including investment, annuity, and insurance holdings;

(j) liquidity needs;

(k) liquid net worth;

(l) risk tolerance, including but not limited to willingness to accept nonguaranteed elements in the annuity;

(m) financial resources used to fund the annuity; and

(n) tax status.

(4) "Continuing education credit" or "CE credit" means one continuing education credit as provided in Title 33, chapter 17.

(5) "Continuing education provider" or "CE provider" means an individual or entity that is approved to offer continuing education courses pursuant to Title 33, chapter 17.

(6) "Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

(7) "Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by producers.

(8) (a) "Material conflict of interest" means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation.

(b) The term does not include cash compensation or noncash compensation.

(9) "Noncash compensation" means any form of compensation that is not cash compensation, including but not limited to health insurance, office rent, office support, and retirement benefits.

(10) "Nonguaranteed elements" means the premiums, credited interest rates including any bonuses, benefits, values, dividends, noninterest-based credits, charges, or elements of formulas used to determine any of these that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(11) "Producer" or "insurance producer" means a person or entity required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, including annuities. For the purposes of this part, the term includes an insurer in which no producer is involved.

(12) (a) "Recommendation" means advice provided by a producer to an individual consumer that was intended to result or does result in a purchase, an exchange, or a replacement of an annuity in accordance with that advice.

(b) The term does not include general communication to the public, generalized customer services, assistance or administrative support, general educational information and tools, prospectuses, or other product and sales material.

(13) "Replacement" means a transaction in which a new annuity is to be purchased, and it is known or should be known to the proposing producer or to the proposing insurer, whether or not a producer is involved, that by reason of the transaction, an existing annuity or other insurance policy or contract has been or is to be any of the following:

(a) lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer, or otherwise terminated;

(b) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(c) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(d) reissued with any reduction in cash value; or

(e) used in a financed purchase.

History: En. Sec. 4, Ch. 476, L. 2007; amd. Sec. 4, Ch. 324, L. 2017; amd. Sec. 3, Ch. 432, L. 2021.

33-20-805. Duties of insurers and producers— best interest obligations. (1) A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest ahead of the consumer's interest. A producer has acted in the best interest of the consumer if the producer has satisfied the following obligations regarding care, disclosure, conflict of interest, and documentation:

(a) The producer, in making a recommendation, shall exercise reasonable diligence, care, and skill to:

(i) know the consumer's financial situation, insurance needs, and financial objectives;

(ii) understand the available recommendation options after making a reasonable inquiry into options available to the producer;

(iii) have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs, and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

(iv) communicate the basis or bases of the recommendation to the consumer in writing.

(b) The requirements under subsection (1)(a)(i) include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

(c) The requirements under subsection (1)(a) require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs, and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers are to be held to standards applicable to producers with similar authority and licensure.

(d) The requirements under this subsection (1) do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this part.

(e) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits, and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs, and financial objectives, but the level of importance of each factor under the care obligation of this section may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

(f) The requirements under subsection (1)(a)(i) include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit, or other insurance-related features.

(g) The requirements under subsection (1)(a)(i) apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any.

(h) The requirements under subsection (1)(a)(i) do not mean the annuity with the lowest one-time or multiple occurrence compensation structure may necessarily be recommended.

(i) The requirements under subsection (1)(a)(i) do not mean the producer has ongoing monitoring obligations under the care obligation under this section, although this obligation may be separately owed under the terms of a fiduciary, consulting, investment advising, or financial planning agreement between the consumer and the producer.

(2) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

(a) the consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living, or other contractual benefits, or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;

(b) the replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(c) the consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

(3) Nothing in this part may be construed to require a producer to obtain a license other than a producer license with the appropriate line of authority to sell, solicit, or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this part, provided the producer does not discuss risks specific to a consumer's individual securities holdings, does not provide advice regarding a consumer's specific securities or securities investment performance, does not compare a consumer's securities or securities investment performance with the annuity products being recommended, does not recommend the liquidation of specific securities or identify specific securities that could be used to fund the purchase of a recommended annuity product, does not recommend specific allocations between insurance and securities products, does not offer research, analysis, or recommendations to a consumer regarding specific securities, and does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

(4) (a) Prior to the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form substantially similar to a model form established by the insurance department:

(i) a description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

(ii) an affirmative statement on whether the producer is licensed and authorized to sell the following products:

(A) fixed annuities;
(B) fixed indexed annuities;
(C) variable annuities;
(D) life insurance;
(E) mutual funds;
(F) stocks and bonds; and
(G) certificates of deposit;

(iii) an affirmative statement describing the insurers the producer is authorized, contracted or appointed, or otherwise able to sell insurance products for, using the following descriptions:

(A) from one insurer;
(B) from two or more insurers; or

(C) from two or more insurers although primarily contracted with one insurer;

(iv) a description of the sources and types of cash compensation and noncash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary, or other producer, or by fee as a result of a contract for advice or consulting services; and

(v) a notice of the consumer's right to request additional information regarding cash compensation described in subsection (4)(b).

(b) On request of the consumer or the consumer's designated representative, the producer shall disclose:

(i) a reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and

(ii) whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages.

(c) Prior to, or at the time of the recommendation or sale of an annuity, the producer has a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders, or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in nonguaranteed elements of the annuity, insurance and investment components, and market risk.

(d) A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.

(e) A producer shall, at the time of recommendation or sale:

(i) make a written record of a recommendation and the basis for the recommendation subject to this part;

(ii) obtain a signed statement from a consumer on a form substantially similar to a model form established by the insurance department documenting:

(A) a customer's refusal to provide the consumer profile information, if any; and

(B) a customer's understanding of the ramifications of not providing the customer's consumer profile information or providing insufficient consumer profile information; and

(iii) obtain a signed statement from a consumer on a form substantially similar to a model form established by the insurance department acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer's recommendation.

(5) Any requirement applicable to a producer under this section must apply to each producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

(6) (a) Except as provided under subsection (6)(b), a producer has no obligation to a consumer under subsection (1) related to any annuity transaction if:

(i) no recommendation is made;

(ii) a recommendation is made but later found to have been prepared based on materially inaccurate information provided by the consumer;

(iii) the consumer refuses to provide relevant consumer profile information and the annuity transaction is not recommended; or

(iv) the consumer decides to enter into an annuity transaction that is not based on a recommendation of the insurer or insurance producer.

(b) An insurer's issuance of an annuity under this subsection (6) must be reasonable under all the circumstances actually known to the insurer at the time the annuity is issued.

(7) (a) Except as permitted under subsection (6), an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe the annuity would

effectively address the particular consumer's financial situation, insurance needs, and financial objectives based on the consumer's consumer profile information.

(b) An insurer shall establish and maintain a supervision system that is reasonably designed to achieve the insurer's and its producers' compliance with this part and, at a minimum, include the following:

(i) the insurer shall establish and maintain reasonable procedures to inform its producers of the requirements of this part and shall incorporate the requirements of this part into relevant producer training manuals;

(ii) the insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its insurance producers to comply with the requirements of 33-20-807;

(iii) the insurer shall provide product-specific training and training materials that explain all material features of its annuity products to its producers;

(iv) the insurer shall establish and maintain procedures for the review of each recommendation prior to the issuance of an annuity that are designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs, and financial objectives. The review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means, including but not limited to physical review. The electronic system or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria.

(v) the insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with subsections (1), (4), (5), (6), (8), and (9). This may include but is not limited to confirmation of the consumer's consumer profile information, systematic consumer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations, and programs of internal monitoring. Nothing in this subsection prevents an insurer from complying with this subsection by applying sampling procedures or by confirming consumer profile information or other required information under this section after issuance or delivery of the annuity.

(vi) the insurer shall establish and maintain reasonable procedures to assess, prior to or on issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section;

(vii) the insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information;

(viii) the insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and noncash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subsection (7) are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits, or other employee benefits by employees as long as those benefits are not based on the volume of sales of a specific annuity within a limited period of time.

(ix) the insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, that details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

(c) (i) Nothing in this subsection (7) restricts an insurer from contracting for performance of a function, including maintenance procedures, required under this subsection (7). An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties under 33-20-806 regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subsection (7)(c)(ii).

(ii) An insurer's supervision system under this subsection (7) must include supervision of contractual performance. This includes but is not limited to the following:

(A) annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has reasonable basis to represent, and does represent that the function is being properly performed; and

(B) monitoring and, as appropriate, conducting audits to ensure that the contracted function is properly performed.

(d) An insurer is not required to include in its system of supervision:

(i) a producer's recommendations to consumers of products other than the annuities offered by the insurer; or

(ii) consideration of or comparison to options available to the producer or compensation relating to those options other than the annuities or other products offered by the insurer.

(8) A producer or an insurer may not dissuade or attempt to dissuade a consumer from:

(a) truthfully responding to an insurer's request for confirmation of the consumer profile information;

(b) filing a complaint; or

(c) cooperating with the investigation of a complaint.

(9) (a) Recommendations and sales of annuities made in compliance with comparable standards must satisfy the requirements under this part. This subsection (9) applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls, and procedures that satisfy a comparable standard even if the standard would not otherwise apply to the product or recommendation at issue. However, nothing in this subsection (9) may limit the insurance commissioner's ability to investigate and enforce the provisions of this part.

(b) Nothing in subsection (9)(a) may limit the insurer's obligation to comply with subsection (7), although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(c) For subsection (9)(a) to apply, an insurer shall:

(i) monitor the relevant conduct of the financial professional seeking to rely on subsection (9)(a) or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal or state securities laws, using information collected in the normal course of an insurer's business; and

(ii) provide to the entity responsible for supervising the financial professional seeking to rely on subsection (9)(a), such as the financial professional's broker-dealer or investment adviser registered under federal or state securities laws, information and reports that are reasonably appropriate to assist the entity to maintain its supervision system.

(d) For the purposes of this subsection, a "financial professional" means a producer that is regulated and acting as:

(i) a broker-dealer registered under federal or state securities laws or a registered representative of a broker-dealer;

(ii) an investment adviser registered under federal or state securities laws or an investment adviser representative associated with the federal or state registered investment adviser; or

(iii) a plan fiduciary under section 3(21) of the Employee Retirement Income Security Act of 1974 or a fiduciary under section 4975(e)(3) of the Internal Revenue Code.

(e) For the purposes of this subsection, a "comparable standards" means:

(i) with respect to broker-dealers and registered representatives of broker-dealers, applicable securities and exchange commission and financial industry regulatory authority rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including but not limited to regulation best interest;

(ii) with respect to investment advisers registered under federal or state securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on the investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940, Title 30, chapter 10, including but not limited to the Form ADV and interpretations; and

(iii) with respect to plan fiduciaries or fiduciaries, the duties, obligations, prohibitions, and all other requirements attendant to the status under the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq., or the Internal Revenue Code.

(10) (a) Insurers, insurance producers, and independent agencies shall maintain or be able to make available to the commissioner records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information

used in making the recommendations that were the basis for insurance transactions for 5 years after the insurance transaction is completed by the insurer. An insurer is permitted, but is not required, to maintain documentation on behalf of a producer.

(b) Records required to be maintained by this section may be maintained in paper, photographic, microprocess, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

History: **En. Sec. 5, Ch. 476, L. 2007; amd. Sec. 5, Ch. 324, L. 2017; amd. Sec. 4, Ch. 432, L. 2021.**

33-20-806. Compliance mitigation — penalties — enforcement. (1) An insurer is responsible for compliance with this part. If a violation occurs, either because of the action or inaction of the insurer or its producer, the commissioner may order:

(a) an insurer or insurance producer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this part by the insurer, an entity contracted to perform the insurer's supervisory duties, or the producer; or

(b) a general agency, independent agency, or the producer to take reasonably appropriate corrective action for any consumer harmed by the producer's violation of this part; and

(c) appropriate penalties and sanctions.

(2) A violation of this part is an unfair trade practice under Title 33, chapter 18. Fines may be imposed pursuant to 33-1-317.

(3) Any applicable penalty for a violation of this part may be reduced or eliminated if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

(4) The authority to enforce compliance with this part is vested exclusively with the commissioner.

History: **En. Sec. 6, Ch. 476, L. 2007; amd. Sec. 5, Ch. 432, L. 2021.**

33-20-807. Producer training. (1) A producer may not solicit the sale of an annuity product unless the producer has adequate knowledge of the product to recommend the annuity and the producer is in compliance with the insurer's standards for product training. A producer may rely on insurer-provided product-specific training standards and materials to comply with this section.

(2) (a) (i) A producer who engages in the sale of annuity products shall complete a one-time, 4-credit training course approved by the department of insurance and provided by the department of insurance-approved education provider.

(ii) Producers who hold a life insurance line of authority on October 1, 2021, and who desire to sell annuities shall complete the requirements of this section within 6 months after October 1, 2021. Individuals who obtain a life insurance line of authority on or after October 1, 2021, may not engage in the sale of annuities until the annuity training course required under this section has been completed.

(b) The minimum length of the training required under this subsection (2) must be sufficient to qualify for at least four continuing education credits, but may be longer.

(c) The training required under this section must include, at a minimum, information on the following topics:

(i) the types of annuities and various classifications of annuities;

(ii) identification of the parties to an annuity;

(iii) how product-specific annuity contract features affect consumers;

(iv) the application of income taxation of qualified and nonqualified annuities;

(v) the primary uses of annuities; and

(vi) appropriate standard of conduct, sales practices, replacement, and disclosure requirements.

(d) Training required under this section may not include any information on marketing, sales techniques, or the specific aspects of a particular insurer's products.

(e) An insurer shall verify that a producer has completed the training under this section before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this section by obtaining certificates of completion of the training course or obtaining reports provided by a database system satisfactory to the commissioner.

(f) A producer who has completed an annuity training course approved by the department of insurance prior to October 1, 2021, shall, within 6 months after October 1, 2021, complete either:

(i) a new four-credit training course approved by the department of insurance after October 1, 2021; or

(ii) an additional one-time, one-credit training course approved by the department of insurance and provided by the department of insurance-approved education provider on appropriate sales practices and replacement and disclosure requirements under this part.

(g) The satisfaction of the components of the training requirements of a course or courses with components substantially similar to the provisions of this section must be considered to satisfy the training requirements of this section in this state.

History: **En. Sec. 1, Ch. 324, L. 2017; amd. Sec. 6, Ch. 432, L. 2021.**

Part 9
Annuity Disclosure

33-20-901. Short title. This part may be referred to as the "Montana Annuity Disclosure Act".

History: **En. Sec. 7, Ch. 476, L. 2007.**

33-20-902. Purpose. The purpose of this part is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and to foster consumer education. This part specifies the minimum information that must be disclosed and the method for disclosing the information in connection with the sale of annuity contracts. The goal of this part is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts.

History: **En. Sec. 8, Ch. 476, L. 2007.**

33-20-903. Applicability. (1) This part applies to all group and individual annuity contracts and certificates except:

(a) registered or nonregistered variable annuities or other registered products;

(b) immediate and deferred annuities that do not contain nonguaranteed elements;

(c) structured settlement annuities; and

(d) as provided in subsection (2), annuities used to fund:

(i) an employee pension plan that is covered by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.;

(ii) a plan described by section 401(a), 401(k), or 403(b) of the Internal Revenue Code, 26 U.S.C. 401(a), 401(k), or 403(b), when the plan, for purposes of the Employment Retirement Income Security Act of 1974, is established or maintained by an employer;

(iii) a governmental plan or church plan defined in section 414 of the Internal Revenue Code, 26 U.S.C. 414, or a deferred compensation plan of a state or local government or a tax-exempt organization under section 457 of the Internal Revenue Code, 26 U.S.C. 457; or

(iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

(2) (a) The provisions of this part apply to annuities used to fund a plan or arrangement when:

(i) the plan or arrangement is funded solely by contributions that an employee elects to make whether on a pretax or after-tax basis;

(ii) the insurer has been notified that plan participants may choose from among two or more fixed annuity providers; and

(iii) there is a direct solicitation of an individual employee by an insurance producer for the purchase of an annuity contract.

(b) As used in this subsection (2), direct solicitation does not include any meeting held by an insurance producer solely for the purpose of educating or enrolling employees in the plan or arrangement.

History: **En. Sec. 9, Ch. 476, L. 2007.**

33-20-904. Definitions. As used in this part, the following definitions apply:

(1) "Contract owner" means the owner named in the annuity contract or a certificate holder in the case of a group annuity contract.

(2) (a) "Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and are not subject to insurer discretion, but the values or amounts cannot be determined until some point after issue.

(b) The term includes premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, and charges or elements of formulas used to determine any of these items.

(c) Determinable elements may be described as guaranteed but not determined at issue.

(d) An element is considered determinable if it was calculated from underlying determinable elements only or from both determinable and guaranteed elements.

(3) "Generic name" means a short title descriptive of the annuity contract being applied for, such as "single premium deferred annuity".

(4) "Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, and charges or elements of formulas used to determine any of these items that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

(5) "Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, noninterest-based credits, and charges or elements of formulas used to determine any of these items that are subject to insurer discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

(6) "Structured settlement annuity" means a qualified funding asset as defined in section 130(d) of the Internal Revenue Code, 26 U.S.C. 130(d), or an annuity that would be a qualified funding asset under section 130(d) except that it is not owned by an assignee under a qualified assignment.

History: En. Sec. 10, Ch. 476, L. 2007.

33-20-905. Standards for disclosure document and buyer's guide. (1) When the application for an annuity contract is taken in a face-to-face meeting, the applicant must be given, at or before the time of application, both the disclosure document and the buyer's guide.

(2) (a) When the application for an annuity contract is taken by means other than in a face-to-face meeting, the applicant must be sent both the disclosure document and the buyer's guide not later than 5 business days after the completed application is received by the insurer.

(b) When an application is received as a result of a direct solicitation through the mail, providing a disclosure document and a buyer's guide in the mailing inviting prospective applicants to apply for an annuity contract satisfies the requirement that the disclosure document and buyer's guide be provided not later than 5 business days after receipt of the application.

(c) When an application is received over the internet, taking reasonable steps to make the disclosure document and buyer's guide available for viewing and printing on the insurer's website satisfies the requirement that the disclosure document and the buyer's guide be provided not later than 5 business days of receipt of the application.

(d) A solicitation for an annuity contract provided in other than a face-to-face meeting must include a statement that the proposed applicant may contact the commissioner's office for a free annuity buyer's guide, or an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity buyer's guide.

(3) When the disclosure document and buyer's guide are not provided at or before the time of application, a free-look period of not less than 15 days must be provided for the applicant to return the annuity contract without penalty. This free-look period must run concurrently with any other free-look period provided under state law.

(4) At a minimum, the following information must be included in the disclosure document:

(a) the generic name of the contract, the company product name, if different, the form number, and the fact that it is an annuity;

(b) the insurer's name and address;

(c) a description of the contract and its benefits, emphasizing its long-term nature, including when appropriate:

(i) the guaranteed elements, nonguaranteed elements, and determinable elements of the contract and their limitations, if any, and an explanation of how the elements operate;

(ii) an explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate, and the fact that rates may change from time to time and are not guaranteed;

(iii) periodic income options both on a guaranteed and nonguaranteed basis;

(iv) any value reductions caused by withdrawals from or surrender of the contract within 10 years of issuance under 33-20-309;

(v) how values in the contract can be accessed;

(vi) the death benefit, if one is available, and how it will be calculated;

(vii) a summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

(viii) the impact of any rider, such as a long-term care rider;

(d) specific dollar amount or percentage charges and fees with an explanation of how they apply; and

(e) information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

(5) Insurers shall define terms used in the disclosure statement in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure statement is directed.

History: En. Sec. 11, Ch. 476, L. 2007; amd. Sec. 2, Ch. 177, L. 2017.

33-20-906. Report to contract owners. (1) For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract.

(2) The report must contain at least the following information:

(a) the beginning and ending date of the current report period;

(b) the accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;

(c) the total amounts, if any, that have been credited, charged to the contract value, or paid during the current report period; and

(d) the amount of outstanding loans, if any, as of the end of the current report period.

History: En. Sec. 12, Ch. 476, L. 2007.

33-20-907. Penalties. In addition to any other penalties provided in Title 33, an insurer or insurance producer that violates a provision of this part also violates 33-18-102.

History: En. Sec. 13, Ch. 476, L. 2007.

Part 10
General Requirements for Group Life

33-20-1001. Group contracts required to meet group requirements. (1) No life insurance policy shall be delivered in this state insuring the lives of more than one individual unless to one of the groups as provided for in 33-20-1101 through 33-20-1106 and unless in compliance with the other applicable provisions of parts 10 through 12 of this chapter.

(2) Subsection (1) above shall not apply to life insurance policies insuring only individuals:

(a) related by blood, marriage, or legal adoption;

(b) having a common interest through ownership of a business enterprise or a substantial legal interest or equity therein and who are actively engaged in the management thereof; or

(c) otherwise having an insurable interest in each other's lives.

History: En. Sec. 328, Ch. 286, L. 1959; R.C.M. 1947, 40-3901; amd. Sec. 151, Ch. 575, L. 1981.

33-20-1002. Employee life insurance defined. "Employee life insurance" is that plan of life insurance, other than salary savings life insurance or pension trust insurance and annuities, under which individual policies are issued to the employees of any employer and when the policies are issued on the lives of not less than five employees at date of issue. Premiums for the policies must be paid by the employer or the trustee of a fund established by the employer either wholly from the employer's funds or funds contributed by the employer or partly from those funds and partly from funds contributed by the insured employees.

History: En. Sec. 349, Ch. 286, L. 1959; R.C.M. 1947, 40-3922; amd. Sec. 1212, Ch. 56, L. 2009.

33-20-1003. Repealed. Sec. 32, Ch. 396, L. 2017.

History: En. Sec. 350, Ch. 286, L. 1959; R.C.M. 1947, 40-3923.

Part 11
Groups and Group Requirements

Part Cross-References

Group disability insurance — same group eligible, 33-22-501.

Physicians' liens — exemptions, 71-3-1118.

33-20-1101. Employee groups. (1) Subject to the requirements in subsections (2) through (5), the lives of a group of individuals may be insured under a policy issued to an employer or to the trustees of a fund established by an employer to insure employees of the employer for the benefit of persons other than the employer. The employer or trustees must be considered the policyholder.

(2) (a) The employees eligible for insurance under the policy must be all of the employees of the employer or all of any class or classes of the employer determined by conditions pertaining to their employment. The policy may provide that the term "employees" includes:

(i) the employees of one or more subsidiary corporations and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietors, or partnerships if the business of the employer and of the employer's affiliated corporations, proprietors, or partnerships is under common control;

(ii) the individual proprietor or partners if the employer is an individual proprietor or a partnership; or

(iii) retired employees.

(b) A director of a corporate employer is not eligible for insurance under the policy unless the director is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director.

(c) An individual proprietor or partner is not eligible for insurance under the policy unless the individual proprietor or partner is actively engaged in and devotes a substantial part of working hours to the conduct of the business of the proprietor or partnership.

(3) (a) Payment of the premium for the insurance must be made by the policyholder from:

(i) the employer's funds or funds contributed by the employer;

(ii) funds contributed by the insured employees or members; or

(iii) funds contributed by a combination of payors in subsections (3)(a)(i) and (3)(a)(ii).

(b) A policy on which no part of the premium is to be derived from funds contributed by the insured employees must insure all eligible employees or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(4) The policy must cover at least two employees at date of issue.

(5) The amount of insurance under the policy must be based upon a plan precluding individual selection either by the employees or by the employer or trustees.

History: En. Sec. 329, Ch. 286, L. 1959; R.C.M. 1947, 40-3902; amd. Sec. 25, Ch. 469, L. 2005; amd. Sec. 1, Ch. 430, L. 2007.

33-20-1102. Labor union groups. The lives of a group of individuals may be insured under a policy issued to a labor union, which shall be deemed the policyholder, to insure members of such union for the benefit of persons other than the union or any of its officials, representatives, or agents, subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all of the members of the union or all of any class or classes thereof determined by conditions pertaining to their employment or to membership in the union, or both.

(2) The premium for the policy shall be paid by the policyholder, either wholly from the union's funds or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. No policy may be issued on which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance.

A policy on which part of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed in force only if at least 75% of the then eligible members, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy must cover at least 25 members at date of issue.

(4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the members or by the union.

History: En. Sec. 330, Ch. 286, L. 1959; R.C.M. 1947, 40-3903.

33-20-1103. Employer and labor union combinations — trustee groups. The lives of a group of individuals may be insured under a policy issued to the trustees of a fund established by two or more employers or by one or more labor unions or by one or more employers and one or more labor unions, which trustees must be considered the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions, subject to the following requirements:

(1) The persons eligible for insurance must be all of the employees of the employers or all of the members of the unions or all of any class or classes of the employees or members determined by conditions pertaining to their employment or to membership in the unions, or to both. The policy may provide that the term "employees" includes retired employees and the individual proprietor or partners if an employer is an individual proprietor or a partnership. A director of a corporate employer may not be eligible for insurance under the policy unless the person is otherwise eligible as a bona fide employee of the corporation by performing services other than usual duties of a director. An individual proprietor or partner may not be eligible for insurance under the policy unless the proprietor or partner is actively engaged in and devotes a substantial part of the individual's time to the conduct of the business of the proprietor or partnership. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(2) The premium for the policy must be paid by the trustees wholly from funds contributed by the employer or employers of the insured persons or by the union or unions, or by both, or partly from the funds and partly from funds contributed by the insured persons. A policy may not be issued on which the entire premium is to be derived from funds contributed by the insured persons specifically for their insurance. A policy on which part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance may be placed in force only if at least 75% of the then eligible persons, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required contributions. A policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons or all except any person for whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy must cover at date of issue at least 100 persons and not less than an average of 5 persons per employer unit, and if the fund is established by the members of an association of employers the policy may be issued if:

(a) either:

(i) the participating employers constitute at date of issue at least 60% of those employer members whose employees are not already covered for group life insurance; or

(ii) the total number of persons covered at date of issue exceeds 600; and

(b) the policy does not require that, if a participating employer discontinues membership in the association, the insurance of the employer's employees shall cease solely by reason of the discontinuance.

(4) The amounts of insurance under the policy must be based upon some plan precluding individual selection either by the insured persons or by the policyholder, employers, or unions.

History: En. Sec. 331, Ch. 286, L. 1959; R.C.M. 1947, 40-3904; amd. Sec. 1213, Ch. 56, L. 2009.

33-20-1104. Public employee groups. The lives of a group of individuals may be insured under a policy issued to an incorporated city, town, or village or an association or league of cities, towns, or villages, an independent school district, state college or university, any association of state employees, and any association of state, county, and city, town, or village employees and any combination of state, county, or city, town, or village employees and any department of the state or county government, which employer or association shall be deemed the policyholder, to insure the employees of any such incorporated city, town, or village, of any such independent school district, of any such state college and university, or of any such department of the state or county government or members of any association of state, county, or city, town, or village employees, for the benefit of persons other than the policyholder, subject to the following requirements:

(1) The employees eligible for insurance under the policy shall be all of the employees of the employer or all of any class or classes thereof determined by conditions pertaining to their employment. The policy may provide that the term "employees" shall include retired employees. A policy issued to insure the employees of a public body may provide that the term "employees" shall include elected or appointed officials.

(2) The premium for the policy shall be paid by the policyholder wholly from funds contributed by it as employer or partly from such funds and partly from funds contributed by the insured employees or wholly from funds contributed by the insured employees, except that:

(a) the employer may deduct from the employees' salaries the required contributions for the premiums when authorized in writing by the respective employees so to do; and

(b) the premium for the policy may be paid by the policyholder wholly or partly from funds contributed by any incorporated city, town, or village policyholder when authorized by the charter of such city, town, or village or as otherwise authorized by law.

(3) Such policy may be placed in force only if at least 75% of the eligible employees, excluding any as to whom evidence of individual insurability is not satisfactory to the insurer, elect to make the required premium contributions and become insured thereunder.

(4) The policy must cover at least 10 employees at date of issue.

History: En. Sec. 332, Ch. 286, L. 1959; R.C.M. 1947, 40-3905.

Cross-References

Public employee group insurance, Title 2, ch. 18, parts 7 and 8.

33-20-1105. Debtor groups. The lives of a group of individuals may be insured under a policy issued to a creditor, who is considered the policyholder, to insure the debtors of the creditor, subject to the following requirements:

(1) The debtors eligible for insurance under the policy must be all of the debtors of the creditor or all of any class or classes of those debtors determined by conditions pertaining to the indebtedness or the purchase giving rise to the indebtedness. The policy may provide that the term "debtors" includes the debtors of one or more subsidiary corporations and the debtors of one or more affiliated corporations, proprietors, or partnerships if the business of the policyholder and of the affiliated corporations, proprietors, or partnerships is under common control.

(2) The premium for the policy must be paid by the policyholder from the creditor's funds, from charges collected from the insured debtors, or from both. A policy on which part or all of the premium is to be derived from the collection from the insured debtors of identifiable charges not required of uninsured debtors may not include, in the class or classes of debtors eligible for insurance, debtors under obligations outstanding at its date of issue without evidence of individual insurability unless at least 75% of the then eligible debtors elect to pay the required charges. A policy on which no part of the premium is to be derived from the collection of identifiable charges must insure all eligible debtors or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy may be issued only if the group of eligible debtors is then receiving new entrants at the rate of at least 100 persons yearly or may reasonably be expected to receive at least 100 new entrants during the first policy year and only if the policy reserves to the insurer the right to require evidence of individual insurability if less than 75% of the new entrants become insured. The policy may exclude from the classes eligible for insurance classes of debtors determined by age.

(4) The amount of insurance on the life of any debtor may not at any time exceed the amount owed by the debtor to the creditor.

(5) The insurance must be payable to the policyholder. Each payment must reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment.

History: En. Sec. 333, Ch. 286, L. 1959; amd. Sec. 1, Ch. 132, L. 1965; R.C.M. 1947, 40-3906; amd. Sec. 1, Ch. 617, L. 1985; amd. Sec. 1214, Ch. 56, L. 2009.

33-20-1106. Credit union groups. The lives of a group of individuals may be insured under a policy issued to a credit union organized pursuant to the laws of the state of Montana or the Federal Credit Union Act, which shall be deemed the policyholder, to insure eligible members for amounts of insurance not in excess of the share balance of each member, based upon some plan which will preclude individual selection, for the benefit of someone other than the credit union or its officials and subject to the following requirements:

(1) The members eligible for insurance under the policy shall be all the members of the credit union who meet standard physical requirement conditions of the insurer or all of any class or classes thereof determined by conditions pertaining to their age or to membership in the credit union or both.

(2) The premiums for the policy shall be paid by the policyholder, either wholly from the credit union's funds or partly from such funds and partly from funds contributed by the insured members specifically for their insurance. No policy may be issued on which the entire premium is to be derived from funds contributed by the insured members specifically for their insurance. A policy on which part of the premium is to be derived from funds contributed by the insured members specifically for their insurance may be placed only if at least 75% of the then eligible members, excluding any as to whom evidence of individual insurability is not satisfactory to the insured, elect to make the required contribution. A policy on which no part of the premium is to be derived from funds contributed by the insured members specifically for their insurance must insure all eligible members or all except any as to whom evidence of individual insurability is not satisfactory to the insurer.

(3) The policy must cover at least 25 members at the date of issue.

History: En. Sec. 334, Ch. 286, L. 1959; R.C.M. 1947, 40-3907.

Cross-References

Credit unions — insurance authorized, 32-3-609.

33-20-1107 through 33-20-1110 reserved.

33-20-1111. Dependents of employee and labor union groups — coverage. Any group life policy issued under 33-20-1101, 33-20-1102, or 33-20-1103 may be extended to insure the employees or members against loss due to the death of their spouses and minor children, or any class or classes of employees, members, spouses, or minor children, subject to the following requirements:

(1) (a) The premium for the insurance must be paid by the policyholder from:

(i) the employer's or union's funds or funds contributed by the employer or union;

(ii) funds contributed by the insured employees or members; or

(iii) a combination of payors in subsections (1)(a)(i) and (1)(a)(ii).

(b) If no part of the premium is to be paid from funds contributed by the employees or members, all eligible employees or members, excluding any as to whose family members evidence of insurability is not satisfactory to the insurer, must be insured with respect to their spouses and children.

(2) The amounts of insurance must be based upon some plan precluding individual selection either by the employees or members or by the policyholder, employer, or union.

(3) (a) Upon termination of the insurance with respect to the members of the family of any employee or member by reason of the employee's or member's termination of employment, termination of membership in the class or classes eligible for coverage under the policy, or death, the spouse is entitled to have issued by the insurer, without evidence of insurability, an individual policy of life insurance, without disability or other supplementary benefits, providing application for the individual policy is made and the first premium is paid to the insurer within 31 days after the termination, subject to the requirements of 33-20-1209(1)(a) through (1)(c).

(b) (i) If the group policy terminates or is amended to terminate the insurance of any class of employees or members and the employee or member is entitled to have issued an individual policy under 33-20-1210, the spouse is also entitled to have issued by the insurer an individual policy, subject to the conditions and limitations provided above.

(ii) If the spouse dies within the period during which the spouse would have been entitled to have an individual policy issued in accordance with this provision, the amount of life insurance that the spouse would have been entitled to have issued under the individual policy must be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium for the individual policy has been made.

(4) Notwithstanding the provisions in 33-20-1208, only one certificate must be issued for delivery to an insured person if a statement concerning any dependent's coverage is included in the certificate.

History: **En. Sec. 336, Ch. 286, L. 1959; amd. Sec. 1, Ch. 215, L. 1977; R.C.M. 1947, 40-3909; amd. Sec. 25, Ch. 198, L. 1979; amd. Sec. 84, Ch. 370, L. 1987; amd. Sec. 2, Ch. 430, L. 2007.**

33-20-1112. Discretionary groups. (1) Subject to the requirements of this section, the lives of a group of individuals may be insured under a policy issued to a group other than one described in this part if the commissioner finds that:

(a) the issuance of the policy is not contrary to the best interest of the public;

(b) the issuance of the policy would result in economies of acquisition or administration; and

(c) the benefits of the policy are reasonable in relation to the premiums charged.

(2) Group life insurance coverage under this section may be offered in this state by an insurer under a policy issued in another state only if this state or another state that has requirements substantially similar to the requirements in subsection (1) has made a determination that the requirements of subsection (1) have been met.

(3) The premium for a policy issued under this section must be paid either from the policyholder's funds, from funds contributed by the covered persons, or from both.

(4) An insurer may exclude or limit the coverage on any individual if the evidence of the individual's insurability is not satisfactory to the insurer.

History: **En. Sec. 1, Ch. 163, L. 2011.**

Part 12

Group Contract Provisions

Part Cross-References

Commissioner to approve policy forms, Title 33, ch. 1, part 5.

33-20-1201. Provisions required in group contracts. A policy of group life insurance or a certificate may not be delivered in this state unless it contains in substance the provisions set forth in this part or provisions that in the opinion of the commissioner are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder. A provision may be omitted from a certificate if the commissioner has determined that the provision is not appropriate in a certificate. However:

(1) 33-20-1207 through 33-20-1211 do not apply to policies issued to a creditor to insure debtors of the creditor;

(2) the standard provisions required for individual life insurance policies do not apply to group life insurance policies; and

(3) if the group life insurance policy is on a plan of insurance other than the term plan, it must contain a nonforfeiture provision or provisions that in the opinion of the commissioner is or are equitable to the insured persons and to the policyholder. However, this subsection may not be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

History: **En. Sec. 337, Ch. 286, L. 1959; R.C.M. 1947, 40-3910; amd. Sec. 39, Ch. 472, L. 1999; amd. Sec. 49, Ch. 227, L. 2001.**

Cross-References

Nonforfeiture provisions — standard life policies, Title 33, ch. 20, part 2.

33-20-1202. Grace period. The group life insurance policy and certificate must contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage must continue in force, unless the policyholder has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period.

History: **En. Sec. 338, Ch. 286, L. 1959; R.C.M. 1947, 40-3911; amd. Sec. 28, Ch. 380, L. 2003.**

Cross-References

Computation of time — which days counted, 1-1-306.

33-20-1203. Incontestability. The group life insurance policy and certificate must contain a provision that the validity of the policy may not be contested, except for nonpayment of premium, after it has been in force for 2 years from its date of issue and that a statement made by any person insured under the policy relating to the person's insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of 2 years during the person's lifetime or unless it is contained in a written instrument signed by the person.

History: **En. Sec. 339, Ch. 286, L. 1959; R.C.M. 1947, 40-3912; amd. Sec. 29, Ch. 380, L. 2003.**

33-20-1204. Application — statements considered representations. The group life insurance policy and certificate must contain a provision that a copy of the application, if any, of the policyholder must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured must be considered representations and not warranties, and that a statement made by any person insured may not be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or to the person's beneficiary.

History: **En. Sec. 340, Ch. 286, L. 1959; R.C.M. 1947, 40-3913; amd. Sec. 30, Ch. 380, L. 2003.**

Cross-References

Representations and warranties — standard provision regarding applications, 33-15-403.

33-20-1205. Insurability. The group life insurance policy and certificate must contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the person's coverage.

History: **En. Sec. 341, Ch. 286, L. 1959; R.C.M. 1947, 40-3914; amd. Sec. 31, Ch. 380, L. 2003.**

33-20-1206. Misstatement of age. The group life insurance policy and certificate must contain a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated. The provision must contain a clear statement of the method of adjustment to be used.

History: **En. Sec. 342, Ch. 286, L. 1959; R.C.M. 1947, 40-3915; amd. Sec. 32, Ch. 380, L. 2003.**

33-20-1207. Payment of benefits. (1) The group life insurance policy and certificate must contain a provision that any benefits becoming due by reason of the death of the person insured are payable to the beneficiary designated by the person insured, subject to the provisions of the policy. In the event there is not a designated beneficiary with regard to all or some of the benefits, then those benefits must be considered a part of the intestate estate, pursuant to 72-2-111. In addition, the insurer may pay a benefit amount not exceeding $500 to any person appearing to the insurer to be equitably entitled to that amount by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

(2) The provisions of 33-20-114(2) must be incorporated into the group life insurance policy and certificate and are applicable as set out in that subsection.

History: **En. Sec. 343, Ch. 286, L. 1959; R.C.M. 1947, 40-3916; amd. Sec. 3, Ch. 469, L. 1985; amd. Sec. 33, Ch. 380, L. 2003.**

33-20-1208. Certificate. The group life insurance policy must contain a provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in 33-20-1209 through 33-20-1211.

History: **En. Sec. 344, Ch. 286, L. 1959; R.C.M. 1947, 40-3917; amd. Sec. 1215, Ch. 56, L. 2009.**

33-20-1209. Conversion on termination of eligibility. (1) The group life insurance policy or certificate must contain a provision that if the insurance or any portion of it on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, the person is entitled to have issued to the person by the insurer, without evidence of insurability, an individual policy of life insurance if the application for the individual policy is made and the first premium is paid to the insurer within 31 days after termination and provided that:

(a) the individual policy must, at the option of the person, be on any one of the forms, including but not limited to term insurance, if the group policy provides for term insurance, then customarily issued by the insurer at the age and for the amount applied for, and must offer benefits at least equal to those under the group coverage;

(b) the individual policy must, at the option of the insured, be in an amount not in excess of the amount of life insurance that ceases because of the termination, less the amount of any life insurance for which the person is insured under any other group policy within 31 days after the termination, provided that any amount of insurance that has matured on or before the date of the termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, may not, for the purposes of this provision, be included in the amount that is considered to cease because of the termination; and

(c) the premium on the individual policy is the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk that the person belongs, and to the person's age attained on the effective date of the individual policy.

(2) A group insurer may meet the requirements of this section by contracting with another insurer to issue conversion policies as described in subsection (1). The conversion carrier must be authorized to act as an insurer in this state and shall submit the conversion policies to the commissioner.

(3) (a) (i) With the consent of the employer, a person covered under a group life insurance policy issued to an employer or to the trustees of a fund established by an employer under 33-20-1101 may continue the person's coverage under the group policy during the person's employment even if there has been a reduction of the person's regular work schedule to less than the minimum number of hours required for eligibility for membership. The premium charged for the continued coverage must be equal to that charged other members of the group.

(ii) The person's coverage under the group ceases if the person subsequently becomes eligible for coverage under another group policy because of employment elsewhere.

(b) A group life insurance policy on which the payment of premiums is provided under 33-20-1101(3)(a)(ii) or (3)(a)(iii) may continue in effect for a person whose regular work schedule has been reduced to less than the minimum number of hours required for eligibility for membership. The premium charged for the continued coverage must be equal to that charged other members of the group, and the provisions of subsection (3)(a)(ii) of this section apply.

History: **En. Sec. 345, Ch. 286, L. 1959; R.C.M. 1947, 40-3918; amd. Sec. 1, Ch. 579, L. 1981; amd. Sec. 50, Ch. 227, L. 2001; amd. Sec. 34, Ch. 380, L. 2003; amd. Sec. 3, Ch. 430, L. 2007.**

Cross-References

Assignment — general provisions, 33-15-414.

33-20-1210. Conversion on termination of policy or certificate. (1) The group life insurance policy or certificate must contain a provision that if the group policy or certificate terminates or is amended to terminate the insurance of any class of insured persons, every person insured under the group policy or certificate at the date of the termination whose insurance terminates and who has been insured for at least 3 years prior to the termination date is entitled to have issued to the person by the insurer an individual policy of life insurance, subject to the same conditions and limitations that are provided by 33-20-1209, except that the group policy or certificate may provide that the amount of the individual policy may not exceed the smaller of:

(a) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy or certificate, less the amount of any life insurance for which the person is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days after the termination; or

(b) $10,000.

(2) A group insurer may meet the requirements of this section by contracting with another insurer to issue conversion policies as described in subsection (1). The conversion carrier must be authorized to act as an insurer in this state and shall submit the conversion policies to the commissioner.

History: **En. Sec. 346, Ch. 286, L. 1959; R.C.M. 1947, 40-3919; amd. Sec. 2, Ch. 579, L. 1981; amd. Sec. 9, Ch. 518, L. 1983; amd. Sec. 51, Ch. 227, L. 2001; amd. Sec. 35, Ch. 380, L. 2003.**

Cross-References

Assignment — general provisions, 33-15-414.

33-20-1211. Death pending conversion. The group life insurance policy or certificate must contain a provision that if a person insured under the policy or certificate dies during the period that the person would have been entitled to have an individual policy issued to the person in accordance with 33-20-1209 or 33-20-1210 and before an individual policy becomes effective, the amount of life insurance that the person would have been entitled to have issued to the person under an individual policy is payable as a claim under the group policy or certificate, whether or not application for the individual policy or the payment of the first premium has been made.

History: **En. Sec. 347, Ch. 286, L. 1959; R.C.M. 1947, 40-3920; amd. Sec. 52, Ch. 227, L. 2001.**

33-20-1212. Notice as to conversion right. If an individual insured under a group life insurance policy or certificate delivered in this state becomes entitled under the terms of the policy or certificate to have an individual policy of life insurance issued to the individual without evidence of insurability, subject to making an application and payment of the first premium within the period specified in the policy and if an individual is not given notice of the existence of the right at least 15 days prior to the expiration date of the period, then the individual must have an additional period to exercise the right, but this section may not be construed to continue any insurance beyond the period provided in the policy. The additional period expires 15 days after the individual is given the notice, but an additional period may not extend beyond 60 days after the expiration date of the period provided in the policy. Written notice presented to the individual or mailed by the policyholder to the last-known address of the individual or mailed by the insurer to the last-known address of the individual as furnished by the policyholder constitutes notice for the purpose of this section.

History: **En. Sec. 348, Ch. 286, L. 1959; R.C.M. 1947, 40-3921; amd. Sec. 53, Ch. 227, L. 2001.**

33-20-1213. Policy and certificate provisions — conformity with state statutes. Each policy and certificate regulated by this part must contain a provision or its equivalent as follows:

"Conformity with Montana statutes. The provisions of this policy or certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy or certificate."

History: **En. Sec. 22, Ch. 798, L. 1991; amd. Sec. 36, Ch. 380, L. 2003.**

Part 13
Viatical Settlements

33-20-1301. Short title. This part may be cited as the "Viatical Settlement Act".

History: **En. Sec. 1, Ch. 298, L. 1997.**

33-20-1302. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Financing entity" means an underwriter, placement agent, lender, or any entity, other than a nonaccredited investor, that has a direct ownership in a policy or certificate that is the subject of a viatical settlement contract, whose sole activity related to the transaction is the provision of funds to effect the viatical settlement contract, and who has an agreement in writing with one or more licensed viatical settlement providers.

(2) "Related provider trust" means a trust established by a licensed viatical settlement provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with the viatical settlement provider under which the licensed viatical settlement provider is responsible for ensuring compliance with all statutory and regulatory requirements

and under which the trust agrees to make all records and files related to viatical settlement transactions available to the commissioner.

(3) "Special purpose entity" means a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets for a financing entity or licensed viatical settlement provider.

(4) (a) "Viatical settlement broker" means an individual who, for a fee, commission, or other consideration:

(i) offers or advertises the availability of viatical settlement contracts;

(ii) introduces holders of life insurance policies or certificates insuring the lives of individuals with a terminal illness or condition to viatical settlement providers; or

(iii) offers or attempts to negotiate viatical settlement contracts between the policyholders or certificate holders and one or more viatical settlement providers.

(b) Viatical settlement broker does not mean an attorney, accountant, or financial planner retained to represent the policyholder or certificate holder unless compensation paid to the attorney, accountant, or consultant is paid by the viatical settlement provider.

(5) (a) "Viatical settlement contract" means a written agreement establishing the terms under which compensation or anything of value will be paid, when the compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of any portion of the insurance policy or certificate of insurance.

(b) The term includes:

(i) a contract for a loan or other financing transaction with a viator secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy; or

(ii) an agreement with a viator to transfer ownership or change the beneficiary designation at a later date regardless of the date that compensation is paid to the viator.

(c) The term does not mean a written agreement entered into between a viator and a person having an insurable interest in the viator's life.

(6) (a) "Viatical settlement provider" means a person who solicits, enters into, or negotiates viatical settlement contracts or offers to enter into or negotiate viatical settlement contracts.

(b) Viatical settlement provider does not mean:

(i) a bank, savings bank, savings and loan association, credit union, or other licensed lending institution that takes an assignment of a life insurance policy only as collateral for a loan;

(ii) an insurer issuing a life insurance policy providing accelerated benefits pursuant to 33-20-127 or pursuant to the laws of the state to which the policy was subject when issued;

(iii) an individual who enters into a single agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit; or

(iv) any corporation, partnership, or partner that purchases a life insurance contract of an employee or retiree of the corporation or of a partner. The settlement made on any contract exempt under this section must be reasonable and subject to the standards imposed on licensees under 33-20-1304.

(7) (a) "Viatical settlement purchase agreement" means a contract or agreement entered into by a viatical settlement purchaser with a viatical settlement provider to purchase a life insurance policy or an interest in a life insurance policy for the purpose of deriving an economic benefit.

(b) A viatical settlement purchase agreement does not include a viatical settlement contract.

(8) (a) "Viatical settlement purchaser" means a person who, for the purpose of deriving an economic benefit:

(i) gives consideration for a life insurance policy or an interest in the death benefits of a life insurance policy; or

(ii) owns, acquires, or is entitled to a beneficial interest in a trust that owns a viatical settlement contract or that is the beneficiary of a life insurance policy that has been or will be the subject of a viatical settlement contract.

(b) A viatical settlement purchaser does not include a licensed viatical settlement provider, a licensed viatical settlement broker, a qualified institutional buyer as defined in 17 CFR 230.144A, a financing entity, a special purpose entity, or a related provider trust.

(9) (a) "Viator" means the owner of a life insurance policy or the certificate holder under a group policy who enters or seeks to enter into a viatical settlement contract. For the purposes of this part, a viator may not be limited to an owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual with a terminal or chronic illness or condition except where specifically addressed.

(b) The term does not include a licensed viatical settlement provider, a licensed viatical settlement broker, a qualified institutional buyer as defined in 17 CFR 230.144A, a financing entity, a special purpose entity, or a related provider trust.

History: En. Sec. 2, Ch. 298, L. 1997; amd. Sec. 2, Ch. 295, L. 2001; amd. Sec. 7, Ch. 493, L. 2003; amd. Sec. 17, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 17, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-20-1303. License requirements. (1) A person may not act as or purport to be a viatical settlement provider unless licensed as a viatical settlement provider under this part.

(2) (a) Except as provided in subsections (2)(b) and (2)(c), an individual may not broker, solicit, or negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or otherwise act on behalf of a viator without first having obtained a license as a viatical settlement broker from the commissioner. An applicant for a viatical settlement broker's license shall:

(i) attend required viatical settlement broker training and pass a viatical settlement broker examination designated by the commissioner by rule; and

(ii) pay a fee for an original viatical settlement broker's license pursuant to 33-2-708. The fees for license renewal and lapsed license reinstatement for a viatical settlement broker's license are as provided in 33-2-708.

(b) A resident or nonresident insurance producer must be considered to meet the licensing requirements of a viatical settlement broker and must be permitted to operate as a viatical settlement broker if the insurance producer is licensed as an insurance producer with a life insurance line of authority in this state or in the insurance producer's home state and has been licensed for at least 1 year. In addition:

(i) not later than 30 days from the first day of operating as a viatical settlement broker, the insurance producer shall notify the commissioner, on a form or in a manner prescribed by the commissioner, that the insurance producer is acting as a viatical settlement broker and shall pay a fee pursuant to 33-2-708(1)(b)(viii). The notification must include an acknowledgment by the insurance producer that the insurance producer will operate as a viatical settlement broker in accordance with this part.

(ii) regardless of the manner in which the insurance producer is compensated, the insurance producer must be considered to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interests of the viator.

(c) If requested by the commissioner, a life insurance producer acting as a viatical settlement broker under this subsection (2) who has previously complied with subsection (2)(b)(i) shall report to the commissioner when renewing a resident or nonresident life insurance producer's license regarding the life insurance producer's intent to continue to act as a viatical settlement broker. The statement regarding an intent to continue acting as a viatical settlement broker must be made on the life insurance producer's license renewal form. An individual who makes a statement pursuant to this subsection (2)(c) may not be charged an additional fee.

(d) The provisions of subsections (2)(a) and (2)(b) do not prohibit an individual licensed as an attorney, certified public accountant, or certified financial planner who is accredited by a nationally recognized accreditation agency, who is retained to represent the viator, and whose compensation is not paid directly or indirectly by the viatical settlement provider from negotiating viatical settlement contracts without having to obtain a license as a viatical settlement broker.

(3) Regardless of the manner in which a viatical settlement broker or insurance producer is compensated, the viatical settlement broker or insurance producer must be considered to represent only the viator and the viatical settlement broker or insurance producer owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interests of the viator.

(4) (a) To obtain a license to transact business as a viatical settlement provider or as a viatical settlement broker, if required to obtain a viatical settlement broker's license under the provisions of subsection (2)(a), an applicant shall apply for the license in a form approved by the commissioner and shall pay the fee required for the application.

(b) The commissioner may request biographical, organizational, locational, financial, employment, and other information on the application form that the commissioner determines to be relevant to the evaluation of applications and to the granting of the license. The commissioner may require a statement of the business plan or plan of operation of the applicant. The commissioner shall require an applicant for a viatical settlement provider license to file with the application for the commissioner's approval a copy of the viatical settlement contract that the applicant intends to use in business under the license.

(c) If an applicant is a corporation, the corporation must be:

(i) incorporated or organized under the laws of this state; or

(ii) a foreign corporation authorized to transact business in this state.

(d) If the applicant is a partnership, the partnership must be organized under the laws of this state.

(e) If the applicant is a business entity other than a corporation or partnership, the business entity must be organized under the laws of this state.

(5) (a) An individual licensed as a viatical settlement broker must meet the continuing education requirements in 33-17-1203.

(b) The hours of continuing education required under subsection (5)(a) must be in the subjects of life insurance, viaticals, or ethics.

(c) For an individual licensed as a viatical settlement broker, the 24-month period for meeting the continuing education requirements must correlate with the broker's license renewal period.

(d) The viatical settlement broker's license of an individual who fails to comply with this continuing education requirement and who has not been granted an extension of time to comply in accordance with 33-17-1203(2) must be terminated and promptly surrendered to the commissioner.

History: En. Sec. 3, Ch. 298, L. 1997; amd. Sec. 2, Ch. 552, L. 2005; amd. Sec. 36, Ch. 44, L. 2007; amd. Sec. 11, Ch. 399, L. 2007; amd. Sec. 20, Ch. 271, L. 2009.

33-20-1304. Issuance of license. (1) The commissioner may issue a license to the applicant if the commissioner determines that the applicant:

(a) has satisfied all of the requirements for the license for which an application is made;

(b) has not engaged in conduct that would authorize the commissioner to refuse to issue a license under this part; and

(c) is financially responsible and has a good business reputation.

(2) If the commissioner denies an application, the commissioner shall inform the applicant and state the grounds for the denial.

(3) An individual may act as a viatical settlement provider or viatical settlement broker under the authority of the license of a firm or of a corporate viatical settlement provider whether or not the individual holds a license as a viatical settlement provider if:

(a) the individual is a member or employee of the firm or is an employee, officer, or director of the corporation; and

(b) the individual is designated by the firm or corporation on its license application or on a form that amends or supplements the application as being authorized to act as a viatical settlement provider under the authority of the license.

History: En. Sec. 4, Ch. 298, L. 1997; amd. Sec. 20, Ch. 157, L. 2023.

33-20-1305. Expiration of license. (1) A license issued under this part expires on its expiration date unless it is renewed on or before its expiration date.

(2) Unless the commissioner designates another date, a license expires on the last day of the month in which the second anniversary of the initial issuance date of the license occurs and on the last day of the month of the second anniversary following each renewal.

History: **En. Sec. 5, Ch. 298, L. 1997.**

33-20-1306. Notification by licensee of material change affecting qualification for license. A licensee shall immediately notify the commissioner of any material change in ownership or control or in any other matter affecting the qualification of the licensee for the license in this state, including keeping the commissioner informed about personnel and address changes.

History: **En. Sec. 6, Ch. 298, L. 1997.**

33-20-1307. Suspension — revocation — refusal to issue or renew license. (1) The commissioner may suspend, revoke, refuse to issue, or refuse to renew a license if the commissioner determines that the licensee or applicant for a license is untrustworthy or incompetent to act as a licensee or is guilty of one or more of the following:

(a) dishonesty, fraud, or gross negligence in the conduct of business as a licensee;

(b) a pattern of unreasonable payments to policyholders or certificate holders;

(c) falsification of an application for the license or renewal of the license or misrepresentation or engagement in any other dishonest act in relation to the application;

(d) conduct resulting in a conviction of a felony under the laws of any state or of the United States;

(e) conviction of any crime, an essential element of which is dishonesty or fraud, under the laws of any state or of the United States;

(f) refusal to renew or cancellation, revocation, or suspension of authority to transact insurance or business as a viatical settlement provider, viatical settlement broker, or similar entity in another state;

(g) failure to pay a civil penalty imposed by final order of the commissioner or to carry out terms of probation set by the commissioner;

(h) refusal by a licensee to be examined or to produce accounts, records, or files for examination, refusal by any officers or employees to give information with respect to the affairs of the licensee, or refusal to perform any other legal obligation as to the examination, when required by the commissioner;

(i) affiliation with or under the same general management or interlocking directorate or ownership as another viatical settlement provider, viatical settlement broker, or insurer, any of which unlawfully transacts business in this state;

(j) failure at any time to meet any qualification for which issuance of the license could have been refused had the failure then existed and been known to the commissioner; or

(k) violation of any rule or order of the commissioner or any provision of Montana law.

(2) The commissioner may suspend or refuse to renew a license immediately and without hearing if the commissioner determines that one or both of the following circumstances exist:

(a) the licensee is insolvent;

(b) the financial condition or business practices of the licensee otherwise pose an imminent threat to the public health, safety, or welfare of the residents of this state.

(3) The commissioner may refuse to issue a license in the name of any business entity if the commissioner believes that any member, officer, employee, stockholder, or partner who may materially influence the conduct of the applicant does not meet the standards of this section.

(4) A viatical settlement provider or viatical settlement broker holding a license that has not been renewed or that has been revoked shall surrender the license to the commissioner at the commissioner's request.

(5) The commissioner may take any other administrative action authorized under Montana law in addition to or in lieu of the actions authorized under this part.

History: **En. Sec. 7, Ch. 298, L. 1997; amd. Sec. 21, Ch. 271, L. 2009.**

33-20-1308. Terms of contract. (1) A viatical settlement contract must be in writing. A viatical settlement provider shall establish in the contract the terms under which the viatical settlement provider will pay compensation or anything of value in return for the policyholder's or certificate holder's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of the insurance policy or certificate to the viatical settlement provider.

(2) A viatical settlement provider may not use a viatical settlement contract in this state unless the viatical settlement provider has filed the contract form with the commissioner and the commissioner has approved the contract form according to the provisions set forth in 33-1-501. The commissioner shall disapprove a viatical settlement contract form if, in the commissioner's judgment, the contract or any provision of the contract is unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the policyholder or certificate holder.

(3) Each viatical settlement contract entered into in this state must contain a provision enabling the policyholder or certificate holder to rescind the contract not later than the 30th day after the date on which the contract is executed by all parties or not later than the 15th day after the policyholder or certificate holder receives the viatical settlement proceeds, whichever is the longer period. In order to rescind a contract, a policyholder or certificate holder who has received the proceeds shall return them to the viatical settlement provider or financing entity.

(4) If a viatical settlement provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract must contain all of the following provisions:

(a) that the viatical settlement provider shall effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. Benefits in excess of the amount viaticated must be paid directly to the viator's beneficiary by the insurance company.

(b) that the premiums to be paid by the viatical settlement provider and the viator will be apportioned unless the viatical settlement contract specifies that all premiums must be paid by the viatical settlement provider. The contract may also require that the viator reimburse the viatical settlement provider for the premiums attributable to the retained interest.

(c) that the viatical settlement provider shall, upon acknowledgment of the perfection of the transfer, either:

(i) advise the insured in writing that the insurance company has confirmed the viator's interest in the policy; or

(ii) provide the insured with a copy of the instrument provided by the insurance company to the viatical settlement provider that acknowledges the viator's interest in the policy.

History: En. Sec. 8, Ch. 298, L. 1997; amd. Sec. 5, Ch. 272, L. 2009.

33-20-1309. Annual report by provider. Unless the commissioner grants a time extension, a viatical settlement provider shall file a report for the preceding calendar year with the commissioner on or before March 1 of each year. The report must be in the form and must contain the information that the commissioner prescribes. The report must be verified as follows:

(1) if the viatical settlement provider is a corporation, by at least two principal officers of the viatical settlement provider;

(2) if the viatical settlement provider is a partnership, by two partners; or

(3) if the viatical settlement provider is not a corporation or a partnership, by the provider's owner and manager.

History: En. Sec. 9, Ch. 298, L. 1997.

33-20-1310. Examination of business and practices of licensee or applicant — maintenance of business records. (1) The commissioner may examine the business and practices of any licensee or applicant for a license when the commissioner determines an examination to be necessary. The commissioner may order a licensee or applicant to produce any records, books, files, or other information reasonably necessary to ascertain whether the licensee or applicant is acting or has acted in violation of the law or contrary to the interests of the public. The licensee or applicant shall pay the expenses incurred in conducting an examination.

(2) A viatical settlement provider shall maintain records of all transactions of viatical settlement contracts of the viatical settlement provider and shall make the records available to the commissioner for inspection during reasonable business hours. The records must be maintained for a period of not less than 5 years from the date of their creation.

(3) The commissioner may at any time require a licensee to fully disclose the identity of all stockholders, partners, officers, and employees.

(4) The names of and individual identification data for all policyholders and certificate holders who have entered viatical settlement contracts with viatical settlement providers are confidential and may not be disclosed except in cases in which the commissioner determines that the merits of public disclosure exceed the demands of individual privacy.

History: **En. Sec. 10, Ch. 298, L. 1997; amd. Sec. 10, Ch. 416, L. 1999.**

33-20-1311. Disclosure of information to policyholder. A viatical settlement provider shall disclose the information specified in this section to the policyholder or certificate holder entering the viatical settlement contract prior to the date on which the viatical settlement contract is signed by all parties. The disclosure must be in the form approved by the commissioner. The information must include the following:

(1) possible alternatives to viatical settlement contracts for persons with terminal illnesses or conditions, including but not limited to accelerated benefits offered by the issuer of the life insurance policy;

(2) the fact that some or all of the proceeds of the viatical settlement may be taxable and that assistance should be sought from a personal tax adviser. Viatical settlement brokers, viatical settlement providers, or their respective employees or agents may not act as personal tax advisers for purposes of this disclosure requirement.

(3) the fact that the viatical settlement could be subject to the claims of creditors;

(4) the fact that receipt of a viatical settlement may adversely affect the recipient's eligibility for medicaid or other government benefits or entitlement and that advice should be obtained from the appropriate agencies;

(5) the right of a policyholder or certificate holder to rescind a viatical settlement contract as provided in 33-20-1308. The disclosure must state the deadlines for rescission and the return of proceeds received.

(6) the date by which the funds will be available to the policyholder or certificate holder and the source of the funds; and

(7) the fact that the viatical settlement contract is void if the viatical settlement provider or viatical settlement broker fails to tender payment of the proceeds as provided in the viatical settlement contract.

History: **En. Sec. 11, Ch. 298, L. 1997; amd. Sec. 3, Ch. 295, L. 2001.**

33-20-1312. Conditions precedent to entering into viatical settlement contract. (1) Before a viatical settlement provider enters into a viatical settlement contract with a policyholder or certificate holder who has a terminal illness or condition, the viatical settlement provider shall first obtain the following:

(a) a written statement from an attending physician that the policyholder or certificate holder is of sound mind and not under constraint or undue influence; and

(b) a witnessed document in which the policyholder or certificate holder:

(i) consents to the viatical settlement contract;

(ii) acknowledges that the illness or condition is terminal;

(iii) represents that the policyholder or certificate holder has a full and complete understanding of the viatical settlement contract;

(iv) confirms that the policyholder or certificate holder has a full and complete understanding of the benefits of the life insurance policy;

(v) releases the medical records of the policyholder or certificate holder relating to the terminal illness or condition; and

(vi) acknowledges that the policyholder or certificate holder has entered into the viatical settlement contract freely and voluntarily.

(2) A viatical settlement provider may enter a viatical settlement contract only after the individual whose life would be the subject of the viatical settlement contract is determined to have a terminal illness or condition, as follows:

(a) if the individual is the policyholder or certificate holder, an attending physician of the policyholder or certificate holder shall make the determination; or

(b) if the individual is a person other than the policyholder or certificate holder, an attending physician of the individual or of the policyholder or certificate holder shall make the determination.

(3) For purposes of this section, "attending physician" means a medical doctor, a doctor of osteopathy, or a naturopathic physician licensed in this state, who is primarily responsible for the treatment or a portion of treatment of the individual whose life would be the subject of the viatical settlement contract.

History: En. Sec. 12, Ch. 298, L. 1997.

33-20-1313. Requirements for entering into viatical settlement contract — prohibitions on finder's fee — solicitations — discrimination — false or misleading advertising or solicitation — misuse of confidential information. (1) A person may not enter into a viatical settlement contract within a 2-year period from the date of issuance of an insurance policy or certificate unless the person certifies to the viatical settlement provider that one or more of the following conditions have been met within the 2-year period:

(a) (i) the policy or certificate was issued upon the person's exercise of conversion rights arising out of a group or individual policy or certificate and the total of the time covered under the conversion policy or certificate plus the time covered by the policy or certificate prior to the conversion equal at least 24 months; and

(ii) the time covered under a group policy or certificate was calculated without regard to any change in insurance carriers if the coverage was continuous and under the same group sponsorship; or

(b) the person submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the 2-year period:

(i) the person is terminally ill or chronically ill; or

(ii) the person has disposed of the person's ownership interest in a closely held corporation pursuant to the terms of a buyout agreement or similar agreement that was in effect at the time that the insurance policy or certificate was issued.

(2) Copies of the certification and independent evidence required under subsection (1) must be submitted by the viatical settlement provider to the insurer when the viatical settlement provider submits a request to the insurer for verification of coverage. The copies must be accompanied by a letter of attestation from the viatical settlement provider that the copies are true and correct copies of the documents received by the viatical settlement provider.

(3) A licensee may not pay or offer to pay a finder's fee, commission, or other compensation to a person described in this subsection (3) in connection with a policy insuring the life of an individual with a terminal illness or condition. The prohibition under this subsection (3) applies with respect to payments or offers of payment to:

(a) the physician, attorney, or accountant of the policyholder, the certificate holder, or the insured individual;

(b) any person other than a physician, attorney, or accountant described in subsection (3)(a) who provides medical, legal, or financial planning services to the policyholder, to the certificate holder, or to the insured individual when the individual is other than the policyholder or certificate holder; or

(c) any person other than one described in subsection (3)(a) or (3)(b) who acts as an agent of the policyholder, certificate holder, or insured individual.

(4) A licensee may not solicit an investor who could influence the treatment of the illness or condition of the individual whose life would be the subject of a viatical settlement contract.

(5) All information solicited or obtained from a policyholder or certificate holder by a licensee is subject to the confidentiality requirements set forth in Title 33, chapter 19. For purposes of this subsection, a licensee must be considered an insurance-support organization as defined in 33-19-104.

(6) A licensee may not discriminate in the making of a viatical settlement contract on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status, or sexual orientation and may not discriminate between persons who have dependents and persons who do not have dependents.

(7) A person licensed pursuant to 33-20-1304 may not engage in any false or misleading advertising, solicitation, or practice as described in 33-18-203.

(8) A person licensed pursuant to 33-20-1304 may not sell another product of insurance to the contract holder unless approval is obtained from the commissioner.

History: En. Sec. 13, Ch. 298, L. 1997; amd. Sec. 3, Ch. 552, L. 2005.

33-20-1314. Payment to escrow or trust account — lump-sum payment. (1) Within 3 business days after receipt of documents from the policyholder or certificate holder effecting the transfer of the insurance policy or certificate, the viatical settlement provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a bank approved by the commissioner, pending acknowledgment of the transfer by the issuer of the life insurance policy. The trustee or escrow agent shall transfer the proceeds due to the policyholder or certificate holder immediately upon receipt of acknowledgment of the transfer from the insurer.

(2) A viatical settlement provider shall make payment of the proceeds of a viatical settlement contract in a lump sum except as provided in this subsection. A viatical settlement provider may not retain any portion of the proceeds. A viatical settlement provider may make installment payments only if the viatical settlement provider has purchased an annuity issued by an authorized insurer or a similar financial instrument issued by a financial institution authorized to engage in the business of a financial institution in this state.

(3) Failure by the viatical settlement provider to tender the viatical settlement by the date disclosed to the policyholder or certificate holder renders the contract void.

History: En. Sec. 14, Ch. 298, L. 1997; amd. Sec. 6, Ch. 272, L. 2009.

33-20-1315. Rules — standards — bond. The commissioner may, in accordance with the provisions of 33-1-313, adopt rules for the purpose of carrying out this part. In addition, the commissioner:

(1) may establish standards for evaluating reasonableness of payments under viatical settlement contracts for insured individuals who are terminally ill or chronically ill. The authority includes but is not limited to regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise, or bequest of a benefit under a life insurance policy. For the purpose of the standards, the commissioner shall consider payments made in regional and national viatical settlement markets to the extent that this information is available, as well as model standards developed by the national association of insurance commissioners. When the insured is not terminally ill or chronically ill, the commissioner may not establish standards for evaluating the reasonableness of payments, except that a viatical settlement provider shall pay an amount greater than the greater of the cash surrender value or the accelerated death benefit then available.

(2) shall require a bond or other mechanism for financial accountability of viatical settlement providers and viatical settlement brokers; and

(3) shall adopt rules to establish:

(a) trade practice standards for the purpose of regulating advertising and solicitation of viatical settlement contracts;

(b) fees that are commensurate with fees charged pursuant to 33-2-708; and

(c) the continuing education program provided for in 33-20-1303(5).

History: En. Sec. 15, Ch. 298, L. 1997; amd. Sec. 8, Ch. 493, L. 2003; amd. Sec. 4, Ch. 552, L. 2005; amd. Sec. 37, Ch. 44, L. 2007; amd. Sec. 12, Ch. 399, L. 2007.

33-20-1316. Service of process. (1) For viatical settlement providers, the provisions of Title 33, chapter 1, part 6, apply.

(2) For viatical settlement brokers, service of process must be made pursuant to 35-7-113 or in any other manner permitted by law.

History: En. Sec. 6, Ch. 227, L. 2001; amd. Sec. 21, Ch. 157, L. 2023.

33-20-1317. Disclosure of information to viatical settlement purchasers. (1) A viatical settlement provider shall disclose the information specified in this section to a viatical settlement purchaser prior to the date on which the parties sign the viatical settlement purchase agreement.

(2) The viatical settlement purchaser shall date and sign the information disclosure. The viatical settlement provider shall provide a copy of the information disclosure to the viatical settlement purchaser.

(3) The information disclosure must include the following:

(a) that the viatical settlement purchaser will not receive payment until the insured dies;

(b) that the actual annual rate of return on a viatical settlement purchase agreement is dependent upon an accurate projection of the insured's life expectancy and the actual date of the insured's death and that an annual guaranteed rate of return is not determinable;

(c) that the viatical insurance contract is not a liquid purchase since it is impossible to predict the exact timing of its maturity, that the funds are probably not available until the death of the insured, and that there is not an established secondary market for the resale of viatical settlement products by the viatical settlement purchaser;

(d) that the viatical settlement purchaser may lose all benefits or may receive substantially reduced benefits if the insurer goes out of business during the term of the viatical settlement investment;

(e) (i) that the viatical settlement purchaser is responsible for payment of the insurance premium or other costs related to the policy, if required by the terms of the viatical purchase agreement, and that these payments may reduce the viatical settlement purchaser's return and may continue beyond the insured's projected life expectancy; and

(ii) if a party other than the viatical settlement purchaser is responsible for the payment, that the name of that party must also be disclosed;

(f) the amount of the premium that a purchaser is required to pay, if applicable;

(g) that the viatical settlement purchaser may be responsible for payment of the insurance premium or other costs related to the policy if the insured returns to health;

(h) the amount of any fees or other expenses to be charged to the viatical settlement purchaser;

(i) whether or not the viatical settlement purchaser is entitled to a refund of all or part of the investment under the viatical settlement purchase agreement if the policy is later determined to be void;

(j) that group policies:

(i) may contain limitations on conversion rights;

(ii) may require additional premiums to be paid if the group policy is converted; and

(iii) may be terminated and replaced by another group policy, with benefits under the new policy that may be substantially less than those in the original coverage;

(k) for group policies, the name of the party responsible for the payment of any additional premiums;

(l) that there are risks associated with policy contestability, including the risk that the viatical settlement purchaser may not have a claim or may have only a partial claim to death benefits if the insurer rescinds the policy within the contestability period;

(m) whether or not the viatical settlement purchaser will be the beneficiary or owner of the policy and, if the viatical settlement purchaser is the beneficiary, the special risks associated with beneficiary status, including the risk that the beneficiary may be changed;

(n) a description of:

(i) the experience and qualifications of the person who has determined the life expectancy of the insured, such as in-house staff, independent physicians, or specialty firms that weigh medical and actuarial data;

(ii) the information on which the projection of life expectancy is based; and

(iii) the relationship of the person who has made the determination of life expectancy to the viatical settlement provider, if any;

(o) all of the life expectancies obtained in the process of determining the price paid to the policyholder or certificate holder;

(p) a description and amount of any loan or other encumbrance against or in connection with the policy; and

(q) that the viatical settlement purchaser is encouraged to consult with an attorney, accountant, or financial planner who is not affiliated with the viatical settlement broker or viatical settlement provider prior to purchase.

History: **En. Sec. 4, Ch. 295, L. 2001; amd. Sec. 72, Ch. 114, L. 2003.**

33-20-1318. Conflict of laws. (1) If there is more than one owner on a single life insurance policy and the owners are residents of different states, the viatical settlement contract is governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all of the owners. The law of the state of the insured governs if equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

(2) (a) A viatical settlement provider from this state who enters into a viatical settlement contract with a viator who is a resident of another state that has enacted statutes or adopted regulations governing viatical settlement contracts is governed in the effectuation of that viatical settlement contract by the statutes and regulations of the viator's state of residence.

(b) A viatical settlement provider from this state who enters into a viatical settlement contract with a viator who is a resident of another state that has not enacted statutes or adopted regulations governing viatical settlement contracts is governed in the effectuation of that viatical settlement contract by the laws of this state. The viatical settlement provider shall give the viator notice that this state regulates the transaction into which the viator is entering. The viatical settlement provider shall maintain all records required by this state and use forms approved in this state.

(3) If there is a conflict in the laws that apply to a viator and a viatical settlement purchaser in any individual transaction, the laws of the state that apply to the viator take precedence and the viatical settlement provider shall comply with those laws.

History: En. Sec. 7, Ch. 272, L. 2009.

Part 14
Structured Settlement Protection

33-20-1401. Short title. This part may be cited as the "Structured Settlement Protection Act".

History: En. Sec. 1, Ch. 351, L. 2005.

33-20-1402. Definitions. As used in this part, unless the context requires otherwise, the following definitions apply:

(1) "Annuity issuer" means an insurer that has issued a contract to fund periodic payments under a structured settlement.

(2) "Consideration" has the meaning provided in 28-2-801.

(3) "Dependent" means a payee's spouse, a minor child of the payee, or any person for whom the payee is legally obligated to provide support, including spousal maintenance.

(4) "Discounted present value" means the present value of future payments determined by discounting the future payments to the present using the most recently published applicable federal rate for determining the present value of an annuity, as issued by the United States internal revenue service.

(5) "Gross advance amount" means the sum payable to the payee or to the payee's account as consideration for a transfer of a structured settlement payment right before any reduction for a transfer expense or any other deduction is made from the sum.

(6) "Independent professional advice" means advice of an attorney, a certified public accountant, an actuary, or any licensed professional adviser.

(7) "Interested party" means, with respect to a structured settlement, the payee, any beneficiary irrevocably designated under the annuity contract to receive a payment after the payee's death, the annuity issuer, the structured settlement obligor, or any other party that has a continuing right or obligation under the structured settlement.

(8) "Net advance amount" means the gross advance amount minus the aggregate amount of the actual and estimated transfer expenses required to be disclosed under 33-20-1403(5).

(9) "Payee" means an individual who is receiving tax-free payments under a structured settlement and proposes to make a transfer of the payment rights.

(10) "Periodic payment" includes both a recurring payment and any scheduled future lump-sum payments.

(11) "Qualified assignment agreement" means an agreement providing for a qualified assignment, as defined for federal tax purposes, of the liability to make periodic payments under a structured settlement.

(12) "Responsible administrative authority" means, with respect to a structured settlement, any government authority vested by law with exclusive jurisdiction over the settled claim resolved by the structured settlement.

(13) "Settled claim" means the original tort claim.

(14) "Structured settlement" means an arrangement for periodic payment of damages for personal injuries or sickness established by settlement or judgment in resolution of a tort claim.

(15) "Structured settlement agreement" means the written agreement, judgment, stipulation, or release embodying the terms of a structured settlement.

(16) "Structured settlement obligor" means, with respect to a structured settlement, the party that has the continuing obligation to make periodic payments to the payee under a structured settlement agreement or a qualified assignment agreement.

(17) "Structured settlement payment right" means the right to receive periodic payments under a structured settlement, whether from the structured settlement obligor or the annuity issuer, when:

(a) (i) the payee is domiciled in this state; or

(ii) the domicile or principal place of business of the structured settlement obligor or the annuity issuer is located in this state;

(b) a court or responsible administrative authority in this state approved the structured settlement agreement; or

(c) the structured settlement agreement is expressly governed by the laws of this state.

(18) "Terms of the structured settlement" means, with respect to a structured settlement, the terms of the structured settlement agreement, the annuity contract, a qualified assignment agreement, or any order or other approval of a court or responsible administrative authority or other government authority that authorized or approved the structured settlement.

(19) (a) "Transfer" means a sale, assignment, pledge, hypothecation, or other alienation or encumbrance of a structured settlement payment right made by a payee for consideration.

(b) The term does not include the creation or perfection of a security interest in a structured settlement payment right under a blanket security agreement entered into with an insured depository institution in the absence of any action:

(i) to redirect the structured settlement payment to the insured depository institution or its agent or successor in interest; or

(ii) to otherwise enforce the blanket security interest against the structured settlement payment right.

(20) "Transfer agreement" means the agreement providing for a transfer of a structured settlement payment right.

(21) (a) "Transfer expenses" means all expenses of a transfer that are:

(i) required under the transfer agreement to be paid by the payee; or

(ii) deducted from the gross advance amount, including without limitation any court filing fee, attorney fee, escrow fee, lien recordation fee, judgment and lien search fee, finder's fee, commission, and other payments to a broker or other intermediary.

(b) Transfer expenses do not include a payee's preexisting obligations that are payable on the payee's account from the proceeds of a transfer.

(22) "Transferee" means a party acquiring or proposing to acquire a structured settlement payment right through a transfer.

History: En. Sec. 2, Ch. 351, L. 2005.

33-20-1403. Disclosure to payee. No less than 3 days prior to the date on which a payee signs a transfer agreement, the transferee shall provide to the payee a written disclosure statement separate from the transfer agreement that sets forth in bold type no smaller than 14 points:

(1) the amounts and the due dates of the structured settlement payment to be transferred;

(2) the aggregate amount of the amounts in subsection (1);

(3) the discounted present value of the payments to be transferred, which must be identified as:

(a) the calculation of the present value of the transferred structured settlement payment under federal standards for valuing annuities; and

(b) the amount of the applicable federal rate used in calculating the discounted present value;

(4) the gross advance amount;

(5) an itemized list of all applicable transfer expenses, other than attorney fees and related disbursements, based on the transferee's best estimate of the amount of fees and disbursements payable in connection with the transferee's application for approval of the transfer;

(6) the net advance amount;

(7) the amount of any penalty or liquidated damages payable by the payee in the event of a breach of the transfer agreement by the payee; and

(8) a statement that the payee has the right to cancel the transfer agreement without penalty or further obligation no later than the third business day after the date on which the payee signs the agreement.

History: **En. Sec. 3, Ch. 351, L. 2005.**

33-20-1404. Transfer of structured settlement payment right — conditions. A direct or indirect transfer of a structured settlement payment right is not effective and a structured settlement obligor or annuity issuer is not required to make a payment directly or indirectly to a transferee of a structured settlement payment right unless a final court order or order of a responsible administrative authority has approved the transfer in advance based on written findings by the court or responsible administrative authority that:

(1) the transfer is in the best interest of the payee, taking into account the welfare and support of the payee's dependents, if any;

(2) the payee has been advised in writing by the transferee to seek independent professional advice regarding the transfer and either has received independent professional advice or knowingly waived independent professional advice in writing; and

(3) the transfer does not contravene any applicable statute or the order of any court or other government authority.

History: **En. Sec. 4, Ch. 351, L. 2005.**

33-20-1405. Obligations after transfer. After the transfer of a structured settlement payment right pursuant to this part:

(1) the structured settlement obligor and the annuity issuer are discharged and released from liability for the transferred payments to all parties except to the transferee;

(2) the transferee is liable to the structured settlement obligor and the annuity issuer:

(a) if the transfer contravenes the terms of the structured settlement for any tax incurred by the structured settlement obligor or annuity issuer as a consequence of the transfer; and

(b) for any other liability or cost, including reasonable costs and attorney fees, arising:

(i) from compliance by the structured settlement obligor and annuity issuer with the order of the court or responsible administrative authority; or

(ii) as a consequence of the transferee's failure to comply with this part; and

(3) neither the structured settlement obligor nor the annuity issuer may be required to divide a periodic payment between a payee and a transferee or assignee or between two or more transferees or assignees.

History: **En. Sec. 5, Ch. 351, L. 2005.**

33-20-1406. Additional transfers. After the transfer of a structured settlement payment right pursuant to this part, any further transfer by the payee is subject to all of the requirements of this part.

History: **En. Sec. 6, Ch. 351, L. 2005.**

33-20-1407. Jurisdiction — notice. (1) A transferee may apply under this part for approval of a transfer of a structured settlement payment right:

(a) in the county in which the payee resides;

(b) in the county in which the structured settlement obligor or the annuity issuer maintains a principal place of business; or

(c) in any court or before any responsible administrative authority that approved the structured settlement agreement.

(2) Not less than 20 days prior to a scheduled hearing on an application for approval of a transfer of a structured settlement payment right under 33-20-1404, the transferee shall file with the court or responsible administrative authority and serve on all interested parties a notice of the proposed transfer and the application for an authorized transfer. The notice must include the following:

(a) a copy of the transferee's application;

(b) a copy of the transfer agreement;

(c) a copy of the disclosure statement required under 33-20-1403;

(d) a listing of each of the payee's dependents, if any, together with the age of each dependent;

(e) notification that any interested party is entitled to support, oppose, or otherwise respond to the transferee's application either in person or by counsel by submitting written comments to the court or responsible administrative authority or by participating in the hearing; and

(f) notification of the time and the place of the hearing and notification of the manner in which and the time by which written responses to the application must be filed. The filing deadline may not be less than 15 days after the transferee's notice has been served.

History: En. Sec. 7, Ch. 351, L. 2005.

33-20-1408. Waiver not allowed. A payee may not waive the provisions of this part.

History: En. Sec. 8, Ch. 351, L. 2005.

33-20-1409. Disputes — entry of judgment. (1) A transfer agreement entered into on or after October 1, 2005, by a payee who resides in this state must provide that disputes under the transfer agreement, including a claim that the payee has breached the agreement, must be determined in this state under the laws of this state.

(2) A transfer agreement may not authorize the transferee or any other party to confess judgment or consent to entry of judgment against the payee.

History: En. Sec. 9, Ch. 351, L. 2005.

33-20-1410. Contingent payment conditions. A transfer of a structured settlement payment right may not extend to a payment that is contingent upon the life of a payee unless prior to the date on which the payee signs the transfer agreement the transferee has established and agreed to maintain procedures reasonably satisfactory to the annuity issuer and the structured settlement obligor for:

(1) periodically confirming the payee's survival; and

(2) giving the annuity issuer and the structured settlement obligor prompt written notice upon the payee's death.

History: En. Sec. 10, Ch. 351, L. 2005.

33-20-1411. Responsibility for compliance — liability. (1) Compliance with the requirements in 33-20-1403 and fulfillment of the conditions in 33-20-1404 are the sole responsibility of the transferee in any transfer of a structured settlement payment right. Neither the structured settlement obligor nor the annuity issuer bears responsibility for or liability arising from noncompliance with 33-20-1403 or failure to fulfill the conditions of 33-20-1404.

(2) A payee who proposes to make a transfer of a structured settlement payment right may not incur a penalty, forfeit an application fee or other payment, or otherwise incur any liability to the proposed transferee or any assignee based on a failure of a transfer agreement to satisfy the conditions of this part.

History: En. Sec. 11, Ch. 351, L. 2005.

33-20-1412. Construction. This part may not be construed to authorize a transfer of a structured settlement payment right in contravention of any law or to imply that any transfer under a transfer agreement entered into prior to October 1, 2005, is valid or invalid.

History: En. Sec. 12, Ch. 351, L. 2005.

Part 15
Funeral Insurance

33-20-1501. Funeral insurance. (1) (a) "Funeral insurance" means an insurance policy or certificate that requires a one-time payment or the payment of premiums to provide for the costs of a funeral and burial for the policyholder or a named individual.

(b) Funeral insurance is a type of life insurance provided for in 33-1-208 and regulated under Title 33, chapter 20. The terms "burial insurance" and "preneed funeral insurance" have the same meaning as funeral insurance.

(c) Funeral insurance may be:

(i) included in a life insurance policy. This form of funeral insurance may not be sold by or through a person licensed under Title 37, chapter 19, regardless of whether a person licensed under Title 37, chapter 19, also has an insurance producer's license in this state.

(ii) a limited policy or certificate with a guaranteed death benefit that may be sold by:

(A) a licensed insurance producer; or

(B) a person licensed under Title 37, chapter 19, parts 3 and 4, if that person also is licensed as a life insurance producer in this state.

(d) Unless otherwise provided by Title 33, chapter 20, the initial policy or certificate limit under subsection (1)(c)(ii) is up to $25,000.

(2) Funeral insurance for the purposes of Title 33 is not a fixed amount prepaid into a trust or escrow fund, called a prearranged funeral plan, as described in 37-19-827, or a preneed arrangement, as defined in 37-19-101, and regulated under Title 37, chapter 19.

(3) A funeral insurance policy and any solicitation material for the policy must clearly indicate that:

(a) the policy is a life insurance product;

(b) the applicant may designate the beneficiary, including but not limited to a funeral director, mortician, mortuary, or undertaker, if the applicant has an insurable interest in the life of the insured; and

(c) subject to the provisions of 33-20-1502 and this section, the beneficiary may use the proceeds for any purpose.

(4) The funeral insurance policy must state that the insurance company shall, as a condition of paying the benefits of the insurance policy, require from the funeral director, mortician, mortuary, or undertaker:

(a) a certified copy of the certificate of death of the insured or other evidence of death satisfactory to the insurance company; and

(b) a certificate of completion signed by the funeral director, mortician, or undertaker stating that the funeral director, mortician, undertaker, or mortuary has delivered all the goods and performed all the services contracted for, by, or on behalf of the insured.

(5) (a) Notwithstanding the provisions of 33-15-414, the funeral insurance policy must contain an assignability clause that allows the policy or certificate to be assigned or otherwise transferred to another funeral director, mortician, mortuary, or undertaker licensed to do business in this state in conjunction with the assumption of the contractual obligation to provide the funeral goods or services to the extent permitted by state or federal law for the purpose of the insured's eligibility for supplemental security income benefits, medicaid, or other public assistance benefits.

(b) The assignability clause may not be used by a funeral director, mortician, mortuary, or undertaker to pledge, assign, transfer, borrow from, or otherwise encumber an insurance policy assigned to it for purposes of purchasing funeral goods or services prior to delivering all of the goods and performing all of the services contracted for, by, or on behalf of the insured.

(6) After the death of a person who at any time received medicaid benefits, a funeral director, mortician, mortuary, undertaker, or other person, including but not limited to the decedent's spouse, heir, devisee, or personal representative, who is the beneficiary of funeral insurance in excess of $5,000 in value designated to pay for the disposition of the medicaid recipient's remains and for related expenses shall, after paying for the disposition and related expenses, pay all remaining funds to the department of public health and human services within 30 days following the receipt of the funeral insurance death benefit. The funds must be paid to the department regardless of any provision in a written contract, insurance policy, or other agreement entered into on or after January 1, 2008, directing a different disposition of the funds. Funds paid to the department under this section are not considered to be property of the deceased medicaid recipient's estate, and the provisions of 53-6-167 do not apply to recovery of the funds by the department.

History: En. Sec. 1, Ch. 507, L. 2007; amd. Sec. 1, Ch. 52, L. 2011; amd. Sec. 1, Ch. 202, L. 2023.

33-20-1502. Excess funeral insurance proceeds. Funeral insurance proceeds that exceed the cost of the funeral goods and services provided must be paid in accordance with the beneficiary designation in the insurance policy or certificate.

History: En. Sec. 2, Ch. 507, L. 2007.

33-20-1503. Rules. The commissioner may adopt rules to regulate funeral insurance, including but not limited to rules regarding licensure of producers, form review, and consumer protection.

History: **En. Sec. 3, Ch. 507, L. 2007.**

Part 16
Unclaimed Life Insurance Benefits Act

33-20-1601. Short title. This part may be cited as the "Unclaimed Life Insurance Benefits Act".

History: **En. Sec. 1, Ch. 119, L. 2013.**

33-20-1602. Purpose. The purposes of this part are to require recognition of the escheat or unclaimed property statutes of Montana and to require complete and proper disclosure, transparency, and accountability relating to any method of payment for life insurance death benefits regulated by the commissioner.

History: **En. Sec. 2, Ch. 119, L. 2013.**

33-20-1603. Application of part. (1) This part applies to life insurance policies, annuity contracts, certificates under a life insurance policy or annuity contract, or certificates issued to a fraternal benefit society under which benefits are payable upon the death of the insured.

(2) This part may not be construed to limit any agreement by the commissioner with an insurer regarding unclaimed life insurance benefits.

(3) For the purposes of this part, the term "annuity contract" does not include an annuity used to fund an employment-based retirement plan or program when the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

History: **En. Sec. 3, Ch. 119, L. 2013; amd. Sec. 16, Ch. 63, L. 2015.**

33-20-1604. Definitions. As used in this part, the following definitions apply:

(1) (a) "Certificate under a life insurance policy" means a certificate of life insurance that provides a death benefit.

(b) The term does not include a certificate of life insurance that provides a death benefit under:

(i) an employee benefit plan that is subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.;

(ii) any federal employee benefit program;

(iii) a policy or certificate used to fund a preneed funeral contract or prearrangement; or

(iv) a policy or certificate of credit life insurance or accidental death insurance.

(2) "Death master file" means the social security administration's death master file or any other database or service at least as comprehensive as the social security administration's death master file used for determining that a person has reportedly died.

(3) "Match" means a search of the death master file that results in a match of the social security number or the name and date of birth of an insured, annuitant, or retained asset account owner.

(4) "Policy" means a policy that provides a death benefit. The term does not include a policy that provides a death benefit under:

(a) an employee benefit plan that is subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.;

(b) any federal employee benefit program;

(c) a policy or certificate of insurance used to fund a preneed funeral contract or prearrangement;

(d) a policy or certificate of credit life insurance or accidental death insurance; or

(e) a policy issued to a group master policyholder for which the insurer does not provide recordkeeping services.

History: **En. Sec. 4, Ch. 119, L. 2013.**

33-20-1605. Insurer conduct. (1) An insurer shall perform a comparison of life insurance policies, annuity contracts, and retained asset accounts that are in force for its insureds against a death master file on at least a semiannual basis to identify potential matches of its insureds. For any potential matches, the insurer shall within 90 days:

(a) make a reasonable effort, documented by the insurer, to confirm the death of the insured, annuity contract holder, or retained asset account holder; and

(b) determine whether benefits are due in accordance with the applicable policy or contract.

(2) If benefits are due in accordance with the applicable policy or contract, the insurer shall:

(a) use reasonable efforts, documented by the insurer, to locate the beneficiary; and

(b) provide the appropriate claims forms or instructions to the beneficiary to make a claim, including the requirement to provide an official death certificate, if applicable under the policy or contract.

(3) With respect to group life insurance, an insurer is required to confirm the possible death of an insured when the insurer maintains at least the following information with regard to those covered under a policy or contract:

(a) social security number or name and date of birth;

(b) beneficiary designation information;

(c) coverage eligibility;

(d) benefit amount; and

(e) premium payment status.

(4) To the extent permitted by law, an insurer may disclose minimum necessary personal information about an insured or beneficiary to a person the insurer reasonably believes may be able to assist the insurer in locating the beneficiary or a person otherwise entitled to payment of claim proceeds.

(5) An insurer or its service provider may not charge insureds, account holders, or beneficiaries for any fees or costs associated with a search or verification conducted pursuant to this section.

(6) The benefits from a life insurance policy, an annuity contract, or a retained asset account, plus any applicable accrued interest, must be first payable to the designated beneficiary. In the event the beneficiary cannot be found, the benefits escheat to the state as unclaimed property pursuant to Title 70, chapter 9, part 8.

(7) If claim proceeds are presumed abandoned pursuant to 70-9-803, the insurer shall notify the department of revenue that:

(a) the beneficiary of a life insurance policy, annuity contract, or retained asset account has not submitted a claim with the insurer; and

(b) the insurer has been unable, after reasonable efforts documented by the insurer, to contact the beneficiary.

(8) In addition to giving notice to the department of revenue, the insurer shall immediately submit the unclaimed life insurance or annuity contract benefits or the unclaimed retained asset accounts, plus any applicable accrued interest, to the department of revenue.

History: En. Sec. 5, Ch. 119, L. 2013.

33-20-1606. Unfair trade practices. A violation of the provisions of 33-20-1605 by an insurer constitutes an unfair method of competition or a deceptive act or practice in the business of insurance as provided in Title 33, chapter 18, part 2.

History: En. Sec. 6, Ch. 119, L. 2013.

CHAPTER 21
CREDIT LIFE AND DISABILITY INSURANCE

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Consumer loans — insurance, 32-5-306.
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Part 1
General Provisions

33-21-101. Short title. This chapter may be cited as "The Model Act for the Regulation of Credit Life Insurance and Credit Disability Insurance".

History: En. Sec. 393, Ch. 286, L. 1959; R.C.M. 1947, 40-4202.

33-21-102. Purpose and scope. (1) The purpose of this chapter is to promote the public welfare by regulating credit life insurance and credit disability insurance. Nothing in this chapter is intended to prohibit or discourage reasonable competition. The provisions of this chapter shall be liberally construed.

(2) Except as provided in subsection (3), this chapter applies to each policy, certificate of insurance, notice of proposed insurance, binder, endorsement, and rider of life insurance and disability insurance delivered or issued for delivery in Montana in connection with loans or other credit transactions for personal, family, or household purposes.

(3) This chapter does not apply to life insurance or disability insurance delivered or issued for delivery in connection with:

(a) a loan or other credit transaction of more than 15 years' duration;

(b) a credit transaction that is:

(i) secured by a first mortgage or deed of trust; and

(ii) made to finance the purchase of real property or the construction of a dwelling thereon or to refinance a prior credit transaction made for that purpose; or

(c) a credit transaction that is an isolated transaction on the part of the insurer and that is not related to an agreement or a plan for insuring debtors of the creditor.

History: **(1)En. Sec. 392, Ch. 286, L. 1959; Sec. 40-4201, R.C.M. 1947; (2)En. Sec. 394, Ch. 286, L. 1959; amd. Sec. 1, Ch. 31, L. 1969; amd. Sec. 1, Ch. 323, L. 1974; Sec. 40-4203, R.C.M. 1947; R.C.M. 1947, 40-4201, 40-4203; amd. Sec. 2, Ch. 617, L. 1985; amd. Sec. 2, Ch. 156, L. 1989.**

Cross-References

Real and personal property — choice by borrower, 33-18-501.

33-21-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Credit disability insurance" means insurance on a debtor or joint debtors to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor or either of the joint debtors is disabled as defined in the policy.

(2) "Credit life insurance" means insurance on the life of a debtor or the lives of joint debtors pursuant to or in connection with a specific loan or other credit transaction.

(3) "Credit transaction" means a transaction by the terms of which, at a future date:

(a) repayment of money loaned is made;

(b) a loan commitment is made; or

(c) payment for goods, services, or property sold or leased is made.

(4) "Creditor" means:

(a) a lender of money or vendor or lessor of goods, services, property, rights, or privileges, for which payment is arranged through a credit transaction;

(b) any successor to the right, title, or interest of a lender, vendor, or lessor;

(c) an affiliate, associate, or subsidiary of a lender, vendor, or lessor;

(d) a director, officer, or employee of a lender, vendor, or lessor; or

(e) any other person in any way associated with a lender, vendor, or lessor.

(5) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction.

(6) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

(7) "Open-end credit" means credit extended by a creditor under an agreement in which:

(a) the creditor reasonably contemplates repeated transactions;

(b) the creditor imposes a finance charge from time to time on an outstanding unpaid balance; and

(c) the amount of credit that may be extended to the debtor during the term of the agreement (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

History: En. Sec. 395, Ch. 286, L. 1959; R.C.M. 1947, 40-4204; amd. Sec. 3, Ch. 156, L. 1989; amd. Sec. 1, Ch. 179, L. 1993.

33-21-104. Existing insurance — choice of insurer. When credit life insurance or credit disability insurance is required as additional security for an indebtedness, the debtor, upon request to the creditor, has the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through an insurer authorized to transact insurance within Montana.

History: En. Sec. 405, Ch. 286, L. 1959; R.C.M. 1947, 40-4214; amd. Sec. 4, Ch. 156, L. 1989; amd. Sec. 1216, Ch. 56, L. 2009.

Cross-References

Retail installment sales — choice of insurer provided, 31-1-233.

33-21-105. Claims. (1) A claim must be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. A claim must be settled as soon as possible and in accordance with the terms of the insurance contract.

(2) A claim must be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions or upon direction of the claimant to one specified.

(3) No plan or arrangement may be used whereby a person, partnership, or corporation other than the insurer or its designated claim representative is authorized to settle or adjust claims. The creditor may not be designated as claim representative for the insurer in adjusting claims, except that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

History: En. Sec. 404, Ch. 286, L. 1959; R.C.M. 1947, 40-4213; amd. Sec. 5, Ch. 156, L. 1989.

Cross-References

Unfair trade practice — delay caused by requiring multiple proofs of loss, 33-18-201.
Administrative penalty for failure to promptly pay claims, 33-18-231, 33-18-232, 33-18-235.

33-21-106 through 33-21-110 reserved.

33-21-111. Rules — enforcement of chapter. The commissioner may, after notice and hearing, adopt rules that the commissioner considers appropriate for the supervision of this chapter. Whenever the commissioner finds that there has been a violation of this chapter or any rules adopted pursuant to this chapter and after written notice and hearing given to the insurer or other person authorized or licensed by the commissioner, the commissioner shall set forth the details of the commissioner's findings together with an order for compliance by a specified date. The order is binding on the insurer and other person authorized or licensed by the commissioner on the date specified unless withdrawn by the commissioner or unless a stay has been ordered by a court of competent jurisdiction.

History: En. Sec. 406, Ch. 286, L. 1959; R.C.M. 1947, 40-4215; amd. Sec. 1217, Ch. 56, L. 2009.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.
Promulgation of rules by Commissioner, 33-1-313.
Hearings by Commissioner, 33-1-701.
Judicial review of Commissioner's decisions — stay of order, 33-1-711.

33-21-112. Judicial review. Any party to the proceeding affected by an order of the commissioner shall be entitled to judicial review by following the procedure set forth in 33-1-711.

History: En. Sec. 407, Ch. 286, L. 1959; R.C.M. 1947, 40-4216.

33-21-113. Penalties. In addition to any penalty provided by law, a person or business entity who violates an order of the commissioner after it has become final and while the order is in effect shall, upon proof of the violation to the satisfaction of a court, pay to the state of Montana a sum not to exceed $250 if the violation is found to be not willful. The sum may be recovered in a civil action. If the violation is found to be willful, the amount of the penalty may be in an amount not to exceed $1,000. The commissioner may revoke or suspend the license or certificate of authority of the person or business entity guilty of the violation. The order for suspension or revocation is subject to judicial review as provided in 33-1-711.

History: En. Sec. 408, Ch. 286, L. 1959; R.C.M. 1947, 40-4217; amd. Sec. 6, Ch. 156, L. 1989; amd. Sec. 1218, Ch. 56, L. 2009; amd. Sec. 22, Ch. 271, L. 2009.

Cross-References

Legal actions by state agencies — Attorney General to be notified, 25-1-501.
Hearings by Commissioner, 33-1-701.
Revocation or suspension of certificate of authority, 33-2-118, 33-2-119.

Part 2
Policy Requirements

Part Cross-References

Retail installment sales — general provisions regarding insurance, 31-1-233.
Consumer loans — applicability and limits, 32-5-306.

33-21-201. Form of issuance. An insurer may deliver or issue for delivery credit life insurance and credit disability insurance only in the following forms:

(1) individual policies of life insurance issued to debtors on a term plan;

(2) individual policies of disability insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(3) group policies of life insurance issued to creditors providing insurance on the lives of debtors on a term plan;

(4) group policies of disability insurance issued to creditors on a term plan insuring debtors or disability provisions in group credit life insurance policies to provide disability coverage;

(5) joint policies of life insurance issued to debtors providing insurance jointly on the lives of joint debtors on a term plan; or

(6) joint policies of disability insurance issued to debtors on a term plan insuring joint debtors or disability provisions in joint credit life insurance policies to provide disability coverage.

History: En. Sec. 396, Ch. 286, L. 1959; R.C.M. 1947, 40-4205; amd. Sec. 7, Ch. 156, L. 1989; amd. Sec. 2, Ch. 179, L. 1993.

33-21-202. Amount. (1) The initial amount of credit life insurance may not exceed the total amount repayable under the contract of indebtedness. If an indebtedness is repayable in substantially equal installments, the amount of credit life insurance may not exceed the scheduled or actual amount of unpaid indebtedness on the date of death, whichever is greater. The amount of credit life insurance written in connection with:

(a) a credit transaction repayable over a term in excess of 63 months or, at the option of the insurer, for a shorter term may not exceed the actual amount of unpaid indebtedness on the date of death, excluding any:

(i) unearned interest or finance charges; and

(ii) delinquency or extension exceeding 4 months;

(b) an open-end credit agreement having a credit limit exceeding $10,000 may not exceed the plan's credit limit;

(c) an agricultural loan commitment not exceeding 1 year may not exceed the amount of the loan commitment on a nondecreasing or level term plan; and

(d) an education loan commitment may be for the amount of the portion of the commitment that has not been advanced by the creditor.

(2) The amount of periodic indemnity payable by credit disability insurance in the event of disability, as defined in the policy, may not exceed:
(a) the aggregate of the periodic scheduled unpaid installments of indebtedness; and
(b) the original indebtedness divided by the number of periodic installments.
(3) A group or individual credit disability insurance policy or a certificate that provides coverage for credit card indebtedness must provide a disability benefit during each credit card billing cycle throughout the term of coverage that, subject to any specified dollar amount limit defined in the policy or certificate, may not be less than the sum of the following amounts payable in the billing cycle and based on the insured balance on the date that an insured disability commences:
(a) the greater of:
(i) the minimum payment required by the creditor for the billing cycle, less any past-due payments and accelerated payments required for the overlimit usage of the credit card; or
(ii) the finance charge calculated pursuant to the credit card contract;
(b) all premiums charged for credit disability insurance coverage; and
(c) all other charges related to the insured balance as of the date the insured disability commences that are incurred in the billing cycle as a result of the insurer's delay in processing a claim payment.

History: En. Sec. 397, Ch. 286, L. 1959; amd. Sec. 2, Ch. 323, L. 1974; R.C.M. 1947, 40-4206; amd. Sec. 8, Ch. 156, L. 1989; amd. Sec. 1, Ch. 530, L. 1997.

Cross-References
Unfair trade practice — failure to promptly pay, 33-18-201.

33-21-203. Term. (1) The term of any credit life insurance or credit disability insurance commences, subject to acceptance by the insurer, on the date on which the debtor becomes obligated to the creditor. However, if a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to the indebtedness commences on the effective date of the policy.

(2) When evidence of insurability is required and the evidence is furnished more than 30 days after the date on which the debtor becomes obligated to the creditor, the term of the insurance may commence on the date the insurer determines the evidence is satisfactory. In that event, the insurer shall make an appropriate refund or adjustment of any charge to the debtor for insurance.

(3) The term of the insurance may not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor, but the term of the insurance may be less than the term of the credit transaction to provide modified or partial coverage or extend beyond the maturity date to provide coverage consistent with 33-21-202(1)(a).

(4) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force must be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund must be paid or credited as provided in 33-21-206.

History: En. Sec. 398, Ch. 286, L. 1959; R.C.M. 1947, 40-4207; amd. Sec. 9, Ch. 156, L. 1989.

33-21-204. Policy or certificate delivered — time of delivery — provisions. (1) All credit life insurance and credit disability insurance sold must be evidenced by an individual policy or, in the case of group insurance, by a certificate of insurance. The individual policy or group certificate of insurance must be delivered to the debtor at the time the indebtedness is incurred except as provided in this section.

(2) If the individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name of each debtor, the premium or amount of payment, if any, by the debtor separately in connection with credit life insurance and credit disability insurance coverage, the amount, term, and a brief description of the coverage provided or to be provided, must be delivered to the debtor at the time the indebtedness is incurred. The copy of the application for or notice of proposed insurance must also refer exclusively to insurance coverage and must be separate and apart from the loan, sale, or other credit statement of account, instrument, or agreement unless

the information required by this section is prominently set forth in the statement of account, instrument, or agreement. Upon approval by the insurer of the application for insurance or acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall deliver the individual policy or group certificate of insurance to the debtor. The application or notice of proposed insurance must state that, upon acceptance by the insurer, the insurance becomes effective as of the date the indebtedness is incurred. If the named insurer does not accept the risk, the debtor must receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged. If the amount of premium is less than that set forth in the notice of proposed insurance, the insurer shall make an appropriate refund.

(3) Each individual policy or group certificate of credit life insurance and credit disability insurance must, in addition to other requirements of law, set forth the name and home office address of the insurer, the name of each debtor or, in the case of a group certificate of insurance, the identity by name or otherwise of the debtor, the rate or amount of payment, if any, by the debtor separately in connection with credit life insurance and credit disability insurance, and a description of the coverages, including the amount and term of the coverages and any exceptions, limitations, or restrictions, and must state that the benefits must be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any excess must be payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate. If the term of the insurance is less than the term of the loan, that fact must be stated on the face of the individual policy or group certificate in not less than 10-point boldface type.

(4) For the purposes of subsections (1) and (2), an individual policy or group certificate of insurance delivered in connection with an open-end credit agreement is considered to be delivered at the time the indebtedness is incurred if delivery occurs on or before the date the indebtedness is incurred.

History: En. Secs. 399, 400, Ch. 286, L. 1959; R.C.M. 1947, 40-4208, 40-4209; amd. Sec. 10, Ch. 156, L. 1989; amd. Sec. 1219, Ch. 56, L. 2009.

33-21-205. Filing, approval, and withdrawal of forms and rates — disapproval. (1) With respect to credit life insurance or credit disability insurance:

(a) a policy, certificate of insurance, notice of proposed insurance, application for insurance, binder, endorsement, or rider may not be delivered or issued for delivery in Montana unless it has been filed with and approved by the commissioner, in accordance with 33-1-501, and the regulatory official of the state in which it is issued; and

(b) a schedule of premium rates pertaining to a policy, certificate of insurance, notice of proposed insurance, application for insurance, binder, endorsement, or rider may not be used in Montana unless it has been filed with the commissioner.

(2) With respect to credit life insurance or credit disability insurance and in accordance with 33-1-501, the commissioner may disapprove a policy, certificate of insurance, notice of proposed insurance, application for insurance, binder, endorsement, or rider:

(a) for a reason listed in 33-1-502;

(b) if the table of premium rates charged or to be charged appears by reasonable assumptions to be excessive in relation to benefits; or

(c) if it contains provisions that are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the insurance.

(3) If the commissioner notifies the insurer that a form is disapproved, it is unlawful for the insurer to issue or use the form.

(4) An insurer may not issue or use a form after the commissioner withdraws approval of the form pursuant to 33-1-501. An order or final determination of the commissioner under this section is subject to judicial review.

History: En. Sec. 401, Ch. 286, L. 1959; R.C.M. 1947, 40-4210; amd. Sec. 11, Ch. 156, L. 1989.

Cross-References

Commissioner to approve forms, Title 33, ch. 1, part 5.
Hearings by Commissioner, 33-1-701.
Judicial review of Commissioner's decisions, 33-1-711.

33-21-206. Premiums and refunds. (1) Each insurer issuing credit life insurance or credit disability insurance shall file with the commissioner its schedules of premium rates for use in connection with such insurance. Any insurer may revise the schedules from time to time and shall file the revised schedules with the commissioner. No insurer may issue any credit life insurance policy or credit disability insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the commissioner. The commissioner may require the filing of the schedule of premium rates for use in connection with and as a part of the specific policy filings as provided by 33-21-205.

(2) Each individual policy, group certificate of insurance, or notice of proposed insurance of credit life insurance and credit disability insurance must provide that, if the insurance is terminated before the scheduled maturity date of the indebtedness, any refund of premium or amount paid by the debtor for insurance must be paid or credited promptly to the person entitled thereto; provided, however, that the commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing refunds must be filed with and approved by the commissioner.

(3) If a creditor requires a debtor to make a payment in connection with credit life insurance or credit disability insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account.

(4) The amount charged to a debtor for any credit life insurance or credit disability insurance may not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(5) Nothing in this chapter may be construed to authorize any payments for insurance prohibited under a statute, or rule thereunder, governing credit transactions.

History: En. Sec. 402, Ch. 286, L. 1959; amd. Sec. 1, Ch. 113, L. 1967; R.C.M. 1947, 40-4211; amd. Sec. 12, Ch. 156, L. 1989.

33-21-207. Issuance of policies. Each policy, certificate of insurance, or notice of proposed insurance of credit life insurance and credit disability insurance must be delivered or issued for delivery in Montana only by an insurer authorized to transact insurance in Montana and must, except as provided in 33-17-103, be issued only through a licensed insurance producer.

History: En. Sec. 403, Ch. 286, L. 1959; R.C.M. 1947, 40-4212; amd. Sec. 13, Ch. 156, L. 1989; amd. Sec. 37, Ch. 16, L. 1991.

Cross-References

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CHAPTER 22
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33-22-1823 through 33-22-1826 reserved.
33-22-1827. Repealed.
33-22-1828. Repealed.

Part 19 — Obstetricians and Gynecologists — Primary Care Physicians

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33-22-1902. Definitions.
33-22-1903. Obstetricians or gynecologists as primary care physicians.
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Part 20 — Small Business Health Insurance Purchasing Pool (Repealed)

Part 21 — Fertility Preservation Services

33-22-2101. Legislative findings — purpose.
33-22-2102. Definitions.
33-22-2103. Coverage of fertility preservation services.
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Part 22 — Dental Insurance Transparency and Accountability Act

33-22-2201. Short title — purpose — scope — exceptions.
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33-22-2203. Transparency of dental insurance premiums.
33-22-2204. Excess revenue — rebate.
33-22-2205. Rulemaking.

Chapter Cross-References

Denial of insurance — credit report — consumer's rights, 31-3-131.
Child support orders — statement concerning required health insurance coverage, 40-4-204.
Child support — health insurance coverage required — enforcement, 40-5-208.
Paternity orders — statement concerning required health insurance coverage, 40-6-116.
Discrimination in insurance and retirement plans, 49-2-309.
Interference prohibited, 50-4-109.
Living will declaration — not required as condition for insurance coverage, 50-9-205.
Living wills — effect on insurance, 50-9-205.
Crime victims compensation claimants — release of insurance payment information concerning, 53-9-104.
Physicians' liens — exemptions, 71-3-1118.

Part 1
General Provisions

Part Cross-References

Collateral source reductions in actions arising from bodily injury or death — subrogation rights, 27-1-308.

33-22-101. Exceptions to scope. (1) Subject to subsection (2), parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-138, 33-22-140, 33-22-141, 33-22-142, 33-22-153, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

(a) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(b) any group or blanket policy;

(c) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance that:

(i) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(ii) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract;

(d) reinsurance.

(2) (a) Sections 33-22-137, 33-22-150 through 33-22-152, 33-22-155, 33-22-170 through 33-22-177, 33-22-180, and 33-22-301 apply to group or blanket policies.

(b) Title 33, chapter 2, part 24, and 33-22-170 through 33-22-177 apply to workers' compensation policies.

History: En. Sec. 351, Ch. 286, L. 1959; R.C.M. 1947, 40-4001; amd. Sec. 26, Ch. 451, L. 1993; amd. Sec. 4, Ch. 527, L. 1995; amd. Sec. 9, Ch. 198, L. 1997; amd. Sec. 4, Ch. 410, L. 1997; amd. Sec. 3, Ch. 416, L. 1997; amd. Sec. 2, Ch. 178, L. 1999; amd. Sec. 40, Ch. 472, L. 1999; amd. Sec. 37, Ch. 380, L. 2003; amd. Sec. 3, Ch. 290, L. 2005; amd. Sec. 26, Ch. 469, L. 2005; amd. Sec. 4, Ch. 356, L. 2007; amd. Sec. 23, Ch. 271, L. 2009; amd. Sec. 3, Ch. 97, L. 2013; amd. Sec. 2, Ch. 164, L. 2013; amd. Sec. 4, Ch. 88, L. 2019; amd. Sec. 2, Ch. 215, L. 2019; amd. Sec. 14, Ch. 501, L. 2021; amd. Sec. 2, Ch. 600, L. 2023.

Cross-References

Disability coverage incidental to another insurance — exclusion from chapter, 33-1-206.
Disability insurance — definition, 33-1-207.

33-22-102. Third-party ownership. The word "insured", as used in parts 1 through 4 of this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits, and rights provided therein.

History: En. Sec. 379, Ch. 286, L. 1959; R.C.M. 1947, 40-4029.

Cross-References

Insurable interest — definition, 33-15-201.

33-22-103. Repealed. Sec. 24, Ch. 227, L. 2011.

History: En. Sec. 384, Ch. 286, L. 1959; R.C.M. 1947, 40-4034.

33-22-104 through 33-22-106 reserved.

33-22-107. Premium increase restriction — exception — notice of rate increase and policy changes. (1) An insurer or a health service corporation that issues or renews a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an individual's group disability insurance policy more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government.

(3) (a) Every health insurance issuer delivering or issuing for delivery group or individual health insurance coverage shall give a group policyholder at least 60 days' advance notice and an individual policyholder at least 45 days' advance notice of a change in rates or a change in terms or benefits.

(b) A notice given under this subsection (3) must be delivered in the following manner:

(i) it must be mailed to the policyholder's last-known address as shown by the records of the insurer; and

(ii) if a health insurance issuer bills any certificate holder directly at the certificate holder's home address for premiums, the notice must be mailed by the health insurer directly to each certificate holder's last-known home address.

(c) If the health insurance issuer fails to provide the notice required by this subsection (3), the coverage must remain in effect at the existing rate with the existing benefits until the full notice period has expired or until the effective date of the replacement coverage obtained by the insured, whichever occurs first.

History: En. Sec. 2, Ch. 699, L. 1991; amd. Sec. 29, Ch. 531, L. 1997; amd. Sec. 38, Ch. 380, L. 2003; amd. Sec. 1, Ch. 384, L. 2003.

33-22-108 reserved.

33-22-109. Riders. (1) Except for group health insurance coverage provided by a group health plan or a health insurance issuer, a policy of disability insurance may contain a provision that excludes coverage for specific conditions through the use of elimination riders for conditions for which medical advice, diagnosis, care, or treatment was recommended by or received from a provider of health care services within 3 years preceding the effective date of coverage of an insured person. The provisions of 33-22-110 do not apply to elimination riders. An insured person may apply to the insurer for removal or modification of a rider, and the insurer shall respond to the application within 60 days of receipt.

(2) An insurer may not, except upon agreement by the insured, retroactively impose an elimination rider on an existing policy, certificate, or contract.

History: En. Sec. 2, Ch. 522, L. 1995; amd. Sec. 4, Ch. 416, L. 1997.

33-22-110. Preexisting conditions. (1) Except as provided in 33-22-246 and 33-22-514, a policy or certificate of disability insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. The condition may only be excluded for a maximum of 12 months.

(2) An insurer may use an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, perform underwriting in accordance with the insurer's established underwriting standards.

(3) A policy of disability income insurance may not exclude coverage for a condition for which medical advice or treatment was recommended by or received from a provider of health care services unless the condition occurred within 5 years preceding the effective date of coverage of an insured person. An exclusion may not apply to a disability commencing more than 12 months from the effective date of coverage of an insured person.

History: En. Sec. 34, Ch. 451, L. 1993; amd. Sec. 1, Ch. 522, L. 1995; amd. Sec. 5, Ch. 416, L. 1997.

33-22-111. Policies and certificates to provide for freedom of choice of practitioners — professional practice not enlarged. (1) All policies or certificates of disability insurance, including individual, group, and blanket policies or certificates, must provide that the insured has full freedom of choice in the selection of any licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, licensed addiction counselor, or advanced practice registered nurse as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of the person's practice. Whenever the policies or certificates insure against the expense of drugs, the insured has full freedom of choice in the selection of any licensed and registered pharmacist.

(2) This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1). This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals.

History: (1)En. Sec. 1, Ch. 172, L. 1967; amd. Sec. 1, Ch. 402, L. 1971; Sec. 40-4108, R.C.M. 1947; (2)En. Sec. 2, Ch. 172, L. 1967; Sec. 40-4109, R.C.M. 1947; R.C.M. 1947, 40-4108, 40-4109; amd. Sec. 1, Ch. 258, L. 1981; amd. Sec. 20, Ch. 303, L. 1981; amd. Sec. 4, Ch. 324, L. 1981; amd. Sec. 1, Ch. 179, L. 1983; amd. Sec. 1, Ch. 302, L. 1985; amd. Sec. 14, Ch. 572, L. 1985; amd. Sec. 1, Ch. 606, L. 1987; amd. Sec. 39, Ch. 83, L. 1989; amd. Sec. 18, Ch. 97, L. 1989; amd. Sec. 1, Ch. 362, L. 1991; amd. Sec. 1, Ch. 628, L. 1993; amd. Sec. 1, Ch. 459, L. 1999; amd. Sec. 41, Ch. 472, L. 1999; amd. Sec. 1, Ch. 235, L. 2001; amd. Sec. 2, Ch. 519, L. 2005; amd. Sec. 1, Ch. 342, L. 2015; amd. Sec. 1, Ch. 206, L. 2017.

Cross-References

Board of Behavioral Health, 2-15-1744; Title 37, ch. 39.
Inapplicability of section to health service corporations, 33-30-102.
Licensed medical professions:
Physicians, Title 37, ch. 3.
Dentists, Title 37, ch. 4.
Chiropodists (podiatrists), Title 37, ch. 6.
Pharmacists, Title 37, ch. 7.
Optometrists, Title 37, ch. 10.
Chiropractors, Title 37, ch. 12.
Clinical psychologists, Title 37, ch. 17.
Workers' Compensation Act, Title 39, ch. 71.
Hospital licensing, Title 50, ch. 5, part 2.

33-22-112. Disability insurance coverage of services of state institutions — provision void — rate of payment. (1) It is unlawful for any insurance company issuing disability insurance policies in Montana to exclude from coverage in a disability insurance policy services rendered the insured while a resident in a Montana state institution if the services to the insured would be covered by the disability insurance policy if rendered to the insured outside a Montana state institution.

(2) A disability insurance policy is considered issued in Montana if the insured purchasing the disability insurance policy is, at the time of the purchase, residing in the state of Montana.

(3) If the exclusion prohibited by this section appears in a disability insurance policy issued in Montana after February 14, 1973, the provision is void and the disability insurance policy will be considered to cover services rendered the insured in a Montana state institution if the services would have been covered if rendered to an insured outside a Montana state institution.

(4) Payment for services rendered in a Montana state institution must be to the same extent and at the same rates, according to the provisions of the disability policy, that would be paid for the services if rendered outside a Montana state institution.

History: En. Secs. 1, 2, 3, 4, Ch. 50, L. 1973; R.C.M. 1947, 40-4035(part), 40-4036, 40-4037, 40-4038; amd. Sec. 1, Ch. 169, L. 1979; amd. Sec. 1220, Ch. 56, L. 2009.

Cross-References

State institutions — Department of Public Health and Human Services, 53-1-602.

33-22-113. Disability insurance coverage of persons eligible for public medical assistance. No disability insurance policy providing hospital, medical, or surgical expense benefits delivered or issued for delivery in this state on or after July 1, 1979, may contain any provision denying or reducing such benefits for the reason that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.

History: En. Sec. 2, Ch. 169, L. 1979.

33-22-114. Coverage required for services provided by physician assistants, advanced practice registered nurses, and registered nurse first assistants. An insurer, a health service corporation, or any employee health and welfare fund that provides accident or health insurance benefits to residents of this state shall provide, in group and individual insurance contracts, coverage as well as payment or reimbursement for health services provided by:

(1) a physician assistant as normally covered by contracts for services supplied by a physician if health care services that the physician assistant performs are covered by the contract;

(2) an advanced practice registered nurse, defined in 37-8-102, as normally covered by contracts for services supplied by a physician or a physician assistant if health care services that the advanced practice registered nurse is approved to perform are covered by the contract; and

(3) a registered nurse first assistant, licensed under Title 37, chapter 8, as normally covered by contracts for surgical services supplied by a physician, a physician assistant, or an advanced practice registered nurse if surgical services that the registered nurse first assistant is approved to perform are covered by the contract.

History: En. Sec. 7, Ch. 97, L. 1989; amd. Sec. 3, Ch. 519, L. 2005; amd. Sec. 1, Ch. 173, L. 2011; amd. Sec. 1, Ch. 88, L. 2023.

Cross-References

Physician assistant defined, 37-20-401.

33-22-115. Provider agreement limited to covered services — dental network constraints — penalty — definitions. (1) A provider agreement entered into or renewed on or after July 1, 2013, between dentists licensed under Title 37, chapter 4, and an issuer that offers an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services may not:

(a) require the dentist to provide dental services to an individual covered under the excepted benefits plan or health benefit plan at a fee set by or subject to the approval of the issuer unless the dental services are covered services; or

(b) prohibit the dentist from offering or providing to an individual covered under the excepted benefits plan or health benefit plan any dental services that are not covered services. The fee for the noncovered services may be determined only under terms or conditions set by the dentist or negotiated by the dentist with the individual covered under the excepted benefits plan or health benefit plan.

(c) provide minimal coverage for covered services under the provider agreement for the sole purpose of avoiding the requirements of this section.

(2) A business entity that owns a network of health care providers and markets access to that network may not circumvent the terms of this section by making available to an issuer of an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services any dentists in that network if the business entity sets dental services fees in its network for any services except covered services.

(3) An issuer of an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services is subject to a fine as provided in 33-1-317 for a violation of this section.

(4) For the purposes of this section, the following definitions apply:

(a) "Covered services" means dental care services provided under a plan for limited-scope dental benefits or a health benefit plan for which a payment is available subject to the application of contractual terms, including but not limited to annual or lifetime maximums, deductibles, copayments, coinsurance, waiting periods, frequency limitations, or alternative benefit reimbursement.

(b) "Issuer" includes an insurer, a health service corporation, or a third-party administrator that offers or administers an excepted benefits plan for limited-scope dental benefits or a health benefit plan that includes covered services.

History: **En. Sec. 1, Ch. 160, L. 2013.**

33-22-116. Prohibition on coverage of abortion services in qualified health plans. (1) A qualified health plan, as defined by 42 U.S.C. 18021, may not be offered or otherwise made available through a health insurance exchange established in the state pursuant to Public Law 111-148, the Patient Protection and Affordable Care Act, if the plan provides coverage for abortion as defined in 50-20-104.

(2) The prohibition in this section does not apply to a plan that provides coverage for an abortion performed when:

(a) the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself; or

(b) the pregnancy is the result of an act of rape or incest.

History: **En. Sec. 1, Ch. 352, L. 2021.**

Cross-References

Montana Abortion Control Act, Title 50, ch. 20, part 1.

33-22-117. Construction. (1) The provisions of 33-22-116 may not be construed as creating or recognizing a right to abortion.

(2) It is not the intent of 33-22-116 to make lawful an abortion that is currently unlawful.

History: **En. Sec. 2, Ch. 352, L. 2021.**

33-22-118 through 33-22-120 reserved.

33-22-121. Notice required for cancellation or refusal to renew. (1) An insurer may not cancel or refuse to renew a disability insurance policy or certificate until the insurer has mailed or delivered to the named insured and to the policyowner or certificate holder, as appropriate if they are not the same as the named insured, at the last-known address shown in the records of the company, one written notice in addition to any billing statement, stating the date the cancellation will become effective, which may not be earlier than:

(a) the beginning of the period for which premiums have not been paid in full if the notice of cancellation for nonpayment of premiums is mailed or delivered within 15 days after the due date of the missed premiums for that period;

(b) the date of mailing or delivery of notice of cancellation for nonpayment of premiums if notice of cancellation for nonpayment of premiums is not mailed or delivered within 15 days after the premium due date for the applicable policy period; or

(c) 90 days after the date of mailing or delivery of the notice of cancellation or refusal to renew for any reason other than nonpayment of premiums or a material misrepresentation contained in the application.

(2) An insurer shall give notice of cancellation at least 30 days in advance of cancellation for nonpayment of premiums or 90 days in advance of cancellation or refusal to renew for any reason other than nonpayment of premiums or a material misrepresentation contained in the application.

(3) An insurer may not cancel a disability insurance policy or a certificate based upon nonpayment of premiums if the premiums are paid in full within the 30-day notice period.

(4) The notice requirements in subsections (1) and (2) run concurrently with any grace period required by 33-22-206.

History: **En. Sec. 3, Ch. 723, L. 1985; amd. Sec. 1, Ch. 191, L. 1989; amd. Sec. 13, Ch. 399, L. 2007.**

33-22-122. Contents of notice — proof — limitation on recovery — exemptions. (1) (a) The notice of cancellation must state:

(i) the amount of the premium, installment, or interest due on the policy or certificate;

(ii) the place where it must be paid; and

(iii) the name and address of the person or company to which the premium is payable.

(b) The notice must also state:

(i) that, unless the premium or other sums are paid to the company or its insurance producer, the policy or certificate will be canceled; and

(ii) the date, determined in accordance with 33-22-121, on which cancellation will become effective.

(2) "Policyowner" or "certificate holder", as used in this section, means the owner of the policy or certificate or any other person designated as the person to receive premium notices, as shown by the records of the insurance company.

(3) If any responsible officer, clerk, or insurance producer of the insurance company authorized to mail the notice states in an affidavit that it is the standard practice of the company to mail to policyowners or certificate holders the notice required by this section, the affidavit is prima facie evidence that the notice has been given.

(4) An action may not be maintained to recover under a lapsed or forfeited policy or certificate on the ground that the insurance company failed to comply with this section unless the action is instituted within 2 years from the due date upon which default was made in paying the premium, installment, or interest for which lapse or forfeiture is claimed.

(5) Section 33-22-121 does not apply to:

(a) group health plans; or

(b) industrial life or industrial disability policies.

History: En. Sec. 4, Ch. 723, L. 1985; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 3, Ch. 384, L. 2003; amd. Sec. 14, Ch. 399, L. 2007.

33-22-123. Return of unearned premium. If an insured pays a premium in advance for coverage to any disability insurer licensed in this state and the insured subsequently cancels the coverage, the disability insurer shall refund the unearned portion of the premium. The disability insurer may consider the premium to be earned only on a calendar-month basis. The disability insurer may not charge the insured any fees or penalty for canceling the coverage. This section does not apply to a short-term disability policy that has a duration of 6 months or less.

History: En. Sec. 1, Ch. 262, L. 2009.

33-22-124 reserved.

33-22-125. Independent chiropractic physical examination or review of records. (1) If a patient's attending health care professional is a licensed chiropractor, the following provisions govern the conduct of a utilization review of the health care services rendered to the patient by the chiropractor:

(a) If an independent physical examination is required by the insurer, it must be conducted by a chiropractor engaged in the practice of chiropractic in Montana.

(b) If a review of the patient's or the chiropractor's records is required by the insurer in the course of an appeal or a redetermination of an adverse determination of medical necessity or appropriateness made pursuant to an insurer's review, the review must be conducted by a person trained in the field of chiropractic. During an appeal or redetermination, the patient may, at the patient's expense, request an independent review of the patient's or the chiropractor's records by a chiropractor engaged in the practice of chiropractic in Montana and may require that review to be considered by the insurer in reaching its decision. If the initial adverse determination of medical necessity or appropriateness is reversed, the insurer shall bear the expense of the independent review.

(2) This section does not prevent a health care insurer from requesting additional medical review of a patient's condition or treatment by another chiropractor or medical provider.

(3) The provisions of this section do not apply to routine claim administration or determination by an insurer.

(4) As used in this section, "health care insurer" means:

(a) an insurer who provides disability insurance as defined in 33-1-207;

(b) a health service corporation as defined in 33-30-101;

(c) a health maintenance organization as defined in 33-31-102;

(d) a fraternal benefit society as defined in 33-7-108;

(e) an administrator as defined in 33-17-102; and

(f) any other entity regulated by the commissioner that provides health care coverage.

History: **En. Sec. 1, Ch. 727, L. 1991; amd. Sec. 1221, Ch. 56, L. 2009.**

33-22-126 reserved.

33-22-127. Coverage of oral therapy — opioid use disorder. A health insurance issuer may not impose prior authorization or step therapy requirements for an oral therapy prescription used to treat opioid use disorder.

History: **En. Sec. 37, Ch. 157, L. 2023.**

33-22-128. Coverage for children who are deaf or hard of hearing — definitions. (1) Health insurance coverage sold in the group or individual market in this state must provide coverage for diagnosis and treatment of various auditory ranges for a covered child 18 years of age or younger in accordance with subsection (2).

(2) (a) Except as provided in subsection (2)(b), coverage under this section, in addition to diagnosis, must include treatment that is:

(i) a medical necessity; and

(ii) prescribed, provided, or ordered by a licensed health care provider to treat various auditory ranges of the covered child.

(b) Treatment may not include more than one hearing device with required accessories or amplification device with required accessories for each ear every 3 years or as required by an audiologist licensed under Title 37, chapter 15.

(3) Benefits provided under this section may not be construed as limiting physical health benefits that are otherwise available to the covered child.

(4) (a) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions and utilization review as provided in Title 33, chapter 32.

(b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage under this section.

(5) This section also applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.

(6) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

(7) As used in this section, the following definitions apply:

(a) "Amplification device" means a hearing device, hearing aid, or wearable, nondisposable, nonexperimental instrument or device designed to aid or compensate for various auditory ranges and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords.

(b) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the view of physicians practicing in relevant clinical areas, and any other relevant factors.

(c) "Health care provider" means an individual licensed under Title 37, chapter 3, 15, or 20. A nurse practitioner licensed under Title 37, chapter 8, also is a health care provider for the purposes of this section.

(d) "Medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

(i) in accordance with generally accepted standards of medical practice;

(ii) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

(e) "Various auditory ranges" means a diversity in the hearing process that may occur in the outer, middle, or inner ear, whereby sound waves are not converted to electrical signals and nerve impulses are not transmitted to the brain to be interpreted.

History: En. Sec. 1, Ch. 209, L. 2021; amd. Sec. 7, Ch. 237, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 7, Ch. 237, L. 2025. Amendment effective October 1, 2025.

33-22-129. Coverage for treatment of diabetes — outpatient self-management training and education — limited benefit for medically necessary equipment and supplies — limitations on cost-sharing requirements for insulin. (1) Each group disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

(2) (a) Coverage must include an annual benefit for medically necessary and prescribed outpatient self-management training and education for the treatment of diabetes. At a minimum, the benefit must consist of:

(i) 20 visits of training and education in diabetes self-management provided in either an individual or group setting if the person has not received the training and education previously; and

(ii) 12 visits of followup diabetes self-management training and education services in subsequent years for an insured who has previously received and exhausted the initial 20 visits of education.

(b) Nothing in subsection (2)(a) prohibits an insurer from providing a greater benefit.

(c) For the purposes of this subsection (2), the term "visit" refers to a period of 30 minutes.

(3) (a) Each group disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for diabetic equipment and supplies that is limited to insulin, syringes, injection aids, devises for self-monitoring of glucose levels (including those for the visually impaired), test strips, visual reading and urine test strips, one insulin pump for each warranty period, accessories to insulin pumps, one prescriptive oral agent for controlling blood sugar levels for each class of drug approved by the United States food and drug administration, and glucagon emergency kits.

(b) Coverage for insulin must limit the insured's required copayment or other cost-sharing requirement for insulin to $35 for up to a 30-day supply of insulin, regardless of the amount or type of insulin prescribed. The limitation in this subsection (3)(b) applies to insulin covered by the insurer's or group health plan's formulary.

(4) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

(6) (a) This section does not apply to any employee group insurance program of a city, town, county, school district, or other political subdivision of this state that on January 1, 2002, provides substantially equivalent or greater coverage for outpatient self-management training and education for the treatment of diabetes and certain diabetic equipment and supplies provided for in subsection (3).

(b) Any employee group insurance program of a city, town, county, school district, or other political subdivision of this state that reduces or discontinues substantially equivalent or greater coverage after January 1, 2002, is subject to the provisions of this section.

History: En. Sec. 1, Ch. 450, L. 2001; amd. Sec. 3, Ch. 54, L. 2011; amd. Sec. 2, Ch. 463, L. 2023; amd. Sec. 3, Ch. 520, L. 2023.

33-22-130. Coverage for adopted children from time of placement — preexisting conditions. (1) Each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for an adopted child of the insured or subscriber to the same extent as for natural children of the insured or subscriber.

(2) The coverage required by this section must be effective from the date of placement for the purpose of adoption and must continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement and may not impose a preexisting condition exclusion.

(3) As used in this section, "placement" means the transfer of physical custody of a child who is legally free for adoption to a person who intends to adopt the child.

History: En. Sec. 1, Ch. 387, L. 1991; amd. Sec. 27, Ch. 451, L. 1993; amd. Sec. 6, Ch. 416, L. 1997; amd. Sec. 161, Ch. 480, L. 1997.

33-22-131. Coverage for treatment of inborn errors of metabolism. (1) Each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

(2) Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(3) For purposes of this section:

(a) "medical foods" means nutritional substances in any form that are:

(i) formulated to be consumed or administered enterally under supervision of a physician;

(ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food;

(iii) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

(iv) essential to optimize growth, health, and metabolic homeostasis;

(b) "treatment" means licensed professional medical services under the supervision of a physician.

(4) These services are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies.

History: En. Sec. 1, Ch. 80, L. 1989; amd. Sec. 28, Ch. 451, L. 1993; amd. Sec. 56, Ch. 379, L. 1995; amd. Sec. 2, Ch. 434, L. 1999.

Cross-References

Health maintenance organizations — coverage for phenylketonuria treatment, 33-31-102.

33-22-132. Coverage for minimum mammography and other breast examinations. (1) Each group or individual medical expense and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage of minimum mammography and other breast examinations as provided in this section.

(2) For the purpose of this section, the following definitions apply:

(a) "Cost-sharing requirement" means a deductible, coinsurance, copayment, and any maximum limitation on the application of a deductible, coinsurance, copayment, or similar out-of-pocket expense.

(b) (i) "Diagnostic breast examination" means a medically necessary and clinically appropriate examination of the breast that is used to evaluate an abnormality seen or suspected from a screening examination for breast cancer or detected by another means of examination.

(ii) The term includes examinations using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.

(c) "Minimum mammography examination" means:

(i) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(ii) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(iii) a mammogram each year for a woman who is 50 years of age or older.

(d) (i) "Supplemental breast examination" means a medically necessary and clinically appropriate examination of the breast that is used to screen for breast cancer when there is no abnormality seen or suspected and is based on personal or family medical history or other factors that may increase a person's risk of breast cancer.

(ii) The term includes examination using breast magnetic resonance imaging or breast ultrasound.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each minimum mammography examination performed before the application of the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establish durational limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) (a) Except as provided in subsection (4)(b), a group health plan or a health insurance issuer offering group or individual health insurance coverage may not impose any cost-sharing requirements for a diagnostic breast examination or supplemental breast examination rendered by a preferred provider as defined in 33-22-1703 when the plan or coverage provides screening benefits, supplemental breast examinations, and diagnostic breast examinations furnished to an individual enrolled under the plan or coverage.

(b) If, under federal law, application of subsection (4)(a) would result in health savings account ineligibility under section 223 of the federal Internal Revenue Code, this requirement may apply only, for health savings account-qualified high deductible health plans with respect to the deductible of the plan after the individual has satisfied the plan's minimum deductible as required by section 223, except for with respect to items or services that are preventive care pursuant to section 223(c)(2)(C) of the federal Internal Revenue Code, in which case the requirements of subsection (4)(a) apply regardless of whether the plan's minimum deductible has been satisfied.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies.

History: En. Sec. 1, Ch. 663, L. 1991; amd. Sec. 29, Ch. 451, L. 1993; amd. Sec. 57, Ch. 379, L. 1995; amd. Sec. 17, Ch. 63, L. 2015; amd. Sec. 1, Ch. 215, L. 2023; amd. Sec. 18, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 18, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-133. Coverage for minimum hospital stay following childbirth. (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health benefit plan, as defined in 33-22-1803, may not terminate the service of an attending health care

provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider.

(5) A health benefit plan, as defined in 33-22-243, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section.

History: En. Sec. 1, Ch. 183, L. 1997.

33-22-134. Postmastectomy care. Each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, also the primary care physician, in consultation with the patient, to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer. This section also applies to any employee group insurance program of a city, town, county, school district, or other political subdivision of the state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974.

History: En. Sec. 1, Ch. 410, L. 1997; amd. Sec. 4, Ch. 54, L. 2011.

Cross-References

University System and local government employee group insurance, 2-18-702.
State group insurance, Title 2, ch. 18, part 8.
Multiple employer welfare arrangements, Title 33, ch. 35.

33-22-135. Coverage for reconstructive breast surgery after mastectomy — benefits and conditions. (1) Each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for:

(a) all stages of reconstruction of the breast on which a mastectomy has been performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prostheses and physical complications of a mastectomy, including lymphedemas.

(2) The treatment covered under subsection (1) must be determined in consultation with the attending physician and the patient.

(3) The coverage required under this section may be subject to annual deductibles and coinsurance provisions consistent with those established for other benefits under an insurance policy, a membership contract, or a certificate of insurance.

(4) For the purposes of this section:

(a) "mastectomy" means the surgical removal of all or part of a breast;

(b) "reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes but is not limited to augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(5) Benefits for reconstructive breast surgery under any contract providing outpatient x-ray or radiation therapy include benefits for outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer that must be included as a part of the outpatient x-ray or radiation therapy benefit.

(6) An insurer shall provide written notice in compliance with the model language of the Women's Health and Cancer Rights Act of 1998 to a covered person of the availability of benefits with respect to the Women's Health and Cancer Rights Act of 1998 upon enrollment and subsequently on an annual basis.

(7) (a) An insurer may not deny to an individual eligibility or continued eligibility to enroll or to renew coverage under the terms of a plan solely for the purpose of avoiding the requirements of this section.

(b) An insurer may not penalize or otherwise reduce or limit the reimbursement of an attending health care provider or provide incentives to an attending health care provider to induce the health care provider to provide care for a covered person in a manner that is inconsistent with this section.

History: En. Sec. 2, Ch. 410, L. 1997; amd. Sec. 1, Ch. 67, L. 2009.

33-22-136. Insurance for spouse and dependents of deceased peace officer, game warden, or firefighter. (1) Any insurer, health service corporation, or health maintenance organization issuing group disability coverage to the spouse or dependents of a peace officer as defined in 45-2-101, a game warden as defined in 19-8-101, a firefighter as defined in 19-13-104, or a volunteer firefighter as defined in 19-17-102 shall renew the coverage of the spouse or dependents if the peace officer, game warden, firefighter, or volunteer firefighter dies within the course and scope of employment. This section also applies to an employee group insurance program of a city, town, county, school district, or other political subdivision of the state, and any self-funded multiple employer welfare arrangement not regulated by the Employee Retirement Income Security Act of 1974 that provides coverage for a peace officer, game warden, firefighter, or volunteer firefighter. Except as provided in subsection (2), the continuation of the coverage is at the option of the spouse or dependents. Renewals of coverage under this section must provide for the same level of benefits as are available to other members of the group. Premiums charged to a spouse or dependent under this section must be the same as premiums charged to other similarly situated members of the group. Dependent special enrollment must be allowed under the terms of 33-22-523(2) and (3). The provisions of this subsection are applicable to a spouse or dependent who is insured under a COBRA continuation provision.

(2) A disability insurance issuer subject to the provisions of subsection (1) may discontinue or not renew the coverage of a spouse or dependent only if:

(a) the spouse or dependent has failed to pay premiums or contributions in accordance with the terms of the disability insurance coverage or if the disability insurer has not received timely premium payments;

(b) the spouse or dependent has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage; or

(c) the disability insurance issuer is ceasing to offer coverage in the group disability market in accordance with applicable state law.

History: En. Sec. 1, Ch. 178, L. 1999; amd. Sec. 5, Ch. 54, L. 2011.

33-22-137. Cost-sharing requirements — applicability. (1) Each group or individual health insurance policy, certificate of insurance, and membership contract that covers prescription drugs and that is delivered, issued for delivery, renewed, extended, or modified in this state must provide that after the applicable deductible is met, the insured shall pay only the required copayment or other cost-sharing requirement for a covered prescription drug at the time of purchase if the prescription drug dispenser, third-party administrator, or health insurance issuer can determine that amount at the time of purchase.

(2) This section applies to blanket policies issued pursuant to Title 33, chapter 22, part 6.

(3) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or long-term care policies.

History: En. Sec. 24, Ch. 271, L. 2009.

33-22-138. Coverage for telehealth services — rulemaking. (1) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for health care services must provide coverage for health care services provided by a health care provider or health care facility by means of telehealth if the services are otherwise covered by the policy, certificate, contract, or agreement.

(2) A policy, certificate, contract, or agreement may not:

(a) impose restrictions involving:

(i) the site at which the patient is physically located and receiving health care services by means of telehealth; or

(ii) the site at which the health care provider is physically located and providing the services by means of telehealth; or

(b) distinguish between telehealth services provided to patients in rural locations and telehealth services provided to patients in urban locations.

(3) Coverage under this section must be equivalent to the coverage for services that are provided in person by a health care provider or health care facility.

(4) Nothing in this section may be construed to require:

(a) a health insurance issuer to provide coverage for services that are not medically necessary, subject to the terms and conditions of the insured's policy;

(b) coverage of an otherwise noncovered benefit;

(c) a health care provider to be physically present with a patient at the site where the patient is located unless the health care provider who is providing health care services by means of telehealth determines that the presence of a health care provider is necessary; or

(d) except as provided in 16-12-509 or as provided in Title 37 and related administrative rules, a patient to have a previously established patient-provider relationship with a specific health care provider in order to receive health care services by means of telehealth.

(5) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions. Deductibles, coinsurance, copayment, or other limitations that are imposed on the coverage for services provided by means of telehealth may not be more than deductibles, coinsurance, copayment, or other limitations that are applicable to other medical services covered under the plan.

(6) This section does not apply to disability income, hospital indemnity, medicare supplement, specified disease, or long-term care policies.

(7) The commissioner may adopt rules necessary to implement the provisions of this section.

(8) For the purposes of this section, the following definitions apply:

(a) "Health care facility" means a critical access hospital, hospice, hospital, long-term care facility, mental health center, outpatient center for primary care, or outpatient center for surgical services licensed pursuant to Title 50, chapter 5.

(b) "Health care provider" means an individual:

(i) licensed pursuant to Title 37, chapter 3, 4, 6, 7, 10, 11, 15, 17, 20, 22, 23, 24, 25, 26, or 35;

(ii) licensed pursuant to Title 37, chapter 8, to practice as a registered professional nurse or as an advanced practice registered nurse;

(iii) certified by the American board of genetic counseling as a genetic counselor; or

(iv) certified by the national certification board for diabetes educators as a diabetes educator.

(c) (i) "Telehealth" means the use of audio, video, or other telecommunications technology or media, including audio-only communication, that is:

(A) used by a health care provider or health care facility to deliver health care services; and

(B) delivered over a secure connection that complies with state and federal privacy laws.

(ii) The term does not include delivery of health care services by means of facsimile machines or electronic messaging alone. The use of facsimile and electronic message is not precluded if used in conjunction with other audio, video, or telecommunications technology or media.

(iii) For physicians providing written certification of a debilitating medical condition pursuant to 16-12-509, the term does not include audio-only communication unless the physician has previously established a physician-patient relationship through an in-person encounter.

History: En. Sec. 1, Ch. 164, L. 2013; amd. Sec. 18, Ch. 63, L. 2015; amd. Sec. 1, Ch. 94, L. 2017; amd. Sec. 4, Ch. 242, L. 2021; amd. Sec. 19, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 19, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-139. Coverage of therapies for Down syndrome. (1) Health insurance coverage sold in the group or individual market in this state must provide coverage for diagnosis and treatment of Down syndrome for a covered child 18 years of age or younger.

(2) Coverage under this section must include:

(a) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child; and

(b) medically necessary therapeutic care that is provided as follows:

(i) up to 104 sessions per year with a speech-language pathologist licensed pursuant to Title 37;

(ii) up to 52 sessions per year with a physical therapist licensed pursuant to Title 37; and

(iii) up to 52 sessions per year with an occupational therapist licensed pursuant to Title 37.

(3) Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention.

(4) Benefits provided under this section may not be construed as limiting physical health benefits that are otherwise available to the covered child.

(5) (a) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions.

(b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage for Down syndrome therapies provided for under this section.

(6) When treatment is expected to require continued services, the insurer may request that the treating physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is medically necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may ask that the treatment plan be updated every 6 months.

(7) As used in this section, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician licensed in this state and that will or is reasonably expected to:

(a) reduce or improve the physical, mental, or developmental effects of Down syndrome; or

(b) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

(8) This section applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.

(9) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

History: En. Sec. 1, Ch. 256, L. 2015.

33-22-140. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

(2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

(3) "COBRA continuation provision" means:

(a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that section as that subsection relates to pediatric vaccines;

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.

(4) (a) "Creditable coverage" means coverage of the individual under any of the following:

(i) a group health plan;

(ii) health insurance coverage;

(iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;

(iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;

(v) Title 10, chapter 55, United States Code;

(vi) a medical care program of the Indian health service or of a tribal organization;

(vii) a health plan offered under Title 5, chapter 89, of the United States Code;

(viii) a public health plan;

(ix) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e); or

(x) a high-risk pool in any state.

(b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

(5) "Dependent" means:

(a) a spouse;

(b) an unmarried child under 25 years of age:

(i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;

(ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;

(iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and

(iv) for whom the insured parent has requested coverage;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined as a dependent in the health benefit plan covering the employee.

(6) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific condition that would otherwise be covered under the policy.

(7) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment.

(8) "Excepted benefits" means:

(a) coverage only for accident or disability income insurance, or both;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for onsite medical clinics;

(h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, as approved by the commissioner;

(i) if offered separately, any of the following:

(i) limited-scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these types of care; or

(iii) other similar, limited benefits as approved by the commissioner;

(j) if offered as independent, noncoordinated benefits, any of the following:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy:

(i) medicare supplement coverage;

(ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United States Code; and

(iii) similar supplemental coverage provided under a group health plan.

(9) "Federally defined eligible individual" means an individual:

(a) for whom, as of the date on which the individual seeks coverage in the group market or individual market, the aggregate of the periods of creditable coverage is 18 months or more;

(b) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any of those plans;

(c) who is not eligible for coverage under:

(i) a group health plan;

(ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4; or

(iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor program;

(d) who does not have other health insurance coverage;

(e) for whom the most recent coverage within the period of aggregate creditable coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(f) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected that coverage; and

(g) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (9)(f) if the individual elected the continuation coverage described in subsection (9)(f).

(10) "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

(11) "Group health plan" means an employee welfare benefit plan, as defined in 29 U.S.C. 1002(1), to the extent that the plan provides medical care and items and services paid for as medical care to employees or their dependents, directly or through insurance, reimbursement, or otherwise.

(12) "Health insurance coverage" means benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer.

(13) (a) "Health insurance issuer" means an insurer, a health service corporation, or a health maintenance organization.

(b) The term does not include a direct patient care agreement established pursuant to 50-4-107.

(14) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(15) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with group health insurance coverage.

(16) "Large employer" means, in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

(17) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan or group health insurance coverage issued to a large employer.

(18) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under 33-22-523, who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if a court has ordered that coverage be provided for a spouse, minor, or dependent under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.

(19) "Medical care" means:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) transportation primarily for and essential to medical care referred to in subsection (19)(a); or

(c) insurance covering medical care referred to in subsections (19)(a) and (19)(b).

(20) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(21) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

(22) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date.

(23) "Small group market" means the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan or group health insurance coverage maintained by a small employer as defined in 33-22-1803.

(24) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan.

History: En. Sec. 33, Ch. 416, L. 1997; amd. Sec. 42, Ch. 472, L. 1999; amd. Sec. 45, Ch. 130, L. 2005; amd. Sec. 27, Ch. 469, L. 2005; amd. Sec. 5, Ch. 356, L. 2007; amd. Sec. 19, Ch. 63, L. 2015; amd. Sec. 9, Ch. 262, L. 2021.

Cross-References

Individual policy requirements, Title 33, ch. 22, part 2.
Group disability insurance, Title 33, ch. 22, part 5.
Small Employer Health Insurance Availability Act, Title 33, ch. 22, part 18.
Child support — medical coverage, 40-5-208.
Medical Support Reform Act, Title 40, ch. 5, part 8.

33-22-141. Crediting previous coverage. (1) (a) A period of creditable coverage may not be counted, with respect to enrollment of an individual under a group health plan, if there was a 63-day break in coverage.

(b) The 63-day period provided for in subsection (1)(a) must be counted from the date that the certificate of creditable coverage was issued to the individual.

(2) The time that an individual is in a waiting period for coverage under a group health plan or for group health insurance coverage or is in an affiliation period, as defined in 33-31-102, may not be considered in determining the continuous period under subsection (1).

(3) Except as provided in subsection (4), for the purposes of applying 33-22-514, a group health plan or a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits coverage during the period.

(4) (a) A group health plan or a health insurance issuer offering group health insurance may elect to apply the provisions of 33-22-514 based on coverage of benefits within each of several classes or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided under subsection (3). If electing to apply the provisions of 33-22-514 pursuant to this subsection (4), a group health plan or a health insurance issuer shall:

(i) make the election on a uniform basis for all participants and beneficiaries; and

(ii) count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) In the case of an election under this subsection (4), a group health plan shall:

(i) prominently state in a disclosure statement concerning the group health plan to each enrollee at the time of enrollment that the group health plan has made an election; and

(ii) include a description of the effect of the election in the statement.

(c) In the case of an election under this subsection (4), a health insurance issuer shall:

(i) prominently state in a disclosure statement concerning the health insurance coverage to each employer at the time of the offer or sale of the health insurance coverage that the health insurance issuer has made an election; and

(ii) include a description of the effect of the election in the statement.

(5) Periods of creditable coverage with respect to an individual must be established through presentation of certifications described in 33-22-142 or in such other manner as may be specified in regulations implementing Public Law 104-191.

History: **En. Sec. 34, Ch. 416, L. 1997; amd. Sec. 4, Ch. 384, L. 2003.**

33-22-142. Certification of creditable coverage. (1) (a) A group health plan and a health insurance issuer offering group or individual health insurance coverage shall issue the certification described in subsection (3) within 10 days after a request by an individual who ceases to be covered under the group or individual health plan.

(b) A request for the certification may be made no later than 24 months after the date of termination of coverage.

(2) The certification may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(3) Certification is the written:

(a) certification of the period of creditable coverage of the individual under a group or individual health plan and the coverage under any applicable COBRA continuation provision;

(b) certification of the waiting period, if any, and affiliation period, as defined in 33-31-102, if applicable, imposed with respect to the individual for any coverage under a group health plan;

(c) certification of the date of issuance of the certificate specified on the form; and

(d) notification to the individual of:

(i) the individual's conversion rights;

(ii) the availability of COBRA continuation coverage; and

(iii) other notification as determined necessary and in the form prescribed by rule by the commissioner.

(4) To the extent that medical care under a group health plan consists of group health insurance coverage, a group health plan satisfies the certification requirement of this section if the health insurance issuer offering the coverage provides the certification in accordance with this section.

(5) In the case of an election described in 33-22-141 by a group health plan or health insurance issuer, if the group health plan or health insurance issuer enrolls an individual for coverage under the group health plan and the individual provides a certification of coverage of the individual, the entity that issued the certification shall upon request of the group health plan or health insurance issuer promptly disclose information on coverage of classes and categories of health benefits available under the certified coverage. The entity may charge the requesting group health plan or health insurance issuer the reasonable cost of disclosing the information.

(6) At the time that an individual ceases to be covered by a group or individual health plan, the group health plan or health insurance issuer shall notify the individual that the individual may request the certification described in subsection (3) within the timeframes described in subsection (1).

History: **En. Sec. 36, Ch. 416, L. 1997; amd. Sec. 5, Ch. 384, L. 2003; amd. Sec. 25, Ch. 271, L. 2009; amd. Sec. 20, Ch. 63, L. 2015; amd. Sec. 1, Ch. 225, L. 2015.**

33-22-143. Rules. The commissioner may adopt rules to implement 33-22-140 through 33-22-142, 33-22-246, 33-22-247, 33-22-514, and 33-22-523 through 33-22-526.

History: **En. Sec. 45, Ch. 416, L. 1997; amd. Sec. 21, Ch. 63, L. 2015.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-22-144 through 33-22-148 reserved.

33-22-149. *(Effective October 1, 2026)* **Reciprocity in gender transition treatment coverage required.** (1) A group or individual insurance policy that includes coverage for gender transition treatment or subsequent treatment directly related to the provision of gender transition treatment must also include coverage for detransition treatment under equivalent cost-sharing policies.

(2) If the group or individual insurance policy ceases coverage for gender transition treatment, the policy is not required to provide equivalent coverage for detransition treatment, except that the policy must provide equivalent coverage to insureds who were enrolled when gender transition treatment coverage was provided and received benefits under that coverage.

(3) For the purposes of this section "gender transition treatment" means the following medical treatments provided:

(a) to a female to address her perception that her gender or sex is not female:

(i) surgical procedures, including a vaginectomy, hysterectomy, oophorectomy, ovariectomy, reconstruction of the urethra, metoidioplasty, phalloplasty, scrotoplasty, implantation of erection or testicular protheses, subcutaneous mastectomy, voice surgery, and pectoral implants;

(ii) supraphysiologic doses of testosterone or other androgens; or

(iii) puberty blockers, such as GnRH agonists or other synthetic drugs that suppress the production of estrogen and progesterone to delay or suppress pubertal development in female minors; and

(b) to a male to address his perception that his gender or sex is not male:

(i) surgical procedures, including a penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty, augmentation mammoplasty, facial feminization surgery, voice surgery, thyroid cartilage reduction, and gluteal augmentation;

(ii) supraphysiologic doses of estrogen; or

(iii) puberty blockers, such as GnRH agonists or other synthetic drugs that suppress the production of testosterone to delay or suppress pubertal development in male minors.

History: En. Sec. 2, Ch. 709, L. 2025.

Compiler's Comments

Effective Date: Section 11, Ch. 709, L. 2025, provided that this section is effective October 1, 2026.

33-22-150. Reciprocal limitations on claim filing and claim audits — time limit for reimbursements or offsets — exceptions. (1) Except as provided in subsection (3), (4), or (5), if a health insurance issuer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer has the same time limit following payment of the claim to perform any review or audit to reconsider the validity of the claim and to request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim.

(2) Except as provided in subsection (3), (4), or (5), if a health insurance issuer does not limit the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.

(3) Regardless of the period allowed by a health insurance issuer for submission of claims for payment, the health insurance issuer may perform a review or audit to reconsider the validity of a claim and may request reimbursement or offset another claim payment for reimbursement of an invalid or overpaid claim within 12 months from the date upon which the health insurance issuer received notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by:

(a) medicare;

(b) a workers' compensation insurer;

(c) another health insurance issuer or group health plan;

(d) a liable or potentially liable third party; or

(e) a foreign health insurance issuer under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.

(4) (a) The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the time specified in subsection (4)(b) if the health insurance issuer pays a claim in which the health insurance issuer:

(i) suspects the health care provider or claimant of insurance fraud related to the claim; and

(ii) has reported evidence of fraud related to the claim to the commissioner pursuant to 33-1-1205.

(b) The time limitation commences running on the date that the commissioner determines that insufficient evidence of fraud exists.

(5) The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the health insurance issuer has actual knowledge of an invalid claim, claim overpayment, or other incorrect payment if the health insurance issuer has paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person. Regardless of the date upon which the health insurance issuer obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, this subsection does not permit the health insurance issuer to request reimbursement or to offset another claim payment for reimbursement of the claim more than 24 months after payment of the claim.

History: En. Sec. 1, Ch. 290, L. 2005; amd. Sec. 20, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 20, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-151. Offset agreement. A health insurance issuer may not collect a claim overpayment or other reimbursement by offsetting another claim payment made to a health care provider or other person unless the health care provider or other person has previously authorized the health insurance issuer in writing to recover an overpayment or other reimbursement by offsetting a future claim payment.

History: En. Sec. 2, Ch. 290, L. 2005.

33-22-152. Continuation of dependent coverage. A health insurance issuer that issues or renews an individual or a group health insurance policy, certificate, or membership contract under which an individual's or employee's dependents are eligible for coverage may not terminate coverage on the basis of the age of an unmarried dependent, as defined in 33-22-140(5)(b), prior to the dependent reaching 25 years of age. Except as otherwise provided by law, the continuation of the coverage of the dependent, as defined in 33-22-140(5)(b), is at the option of the covered employee.

History: En. Sec. 1, Ch. 356, L. 2007.

33-22-153. Coverage of routine patient costs for participants in cancer clinical trials — definitions — limitations. (1) A plan of group or individual health insurance coverage that is delivered, issued for delivery, renewed, extended, or modified in this state may not:

(a) deny participation by a qualified individual in an approved clinical trial;

(b) deny, limit, or impose additional conditions on the coverage of routine patient costs; or

(c) discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

(2) A network plan may require a qualified individual who wishes to participate in an approved clinical trial to participate in a trial that is offered through a provider who is part of the network plan if the provider is participating in the trial and the provider accepts the individual as a participant in the trial.

(3) This section applies to a qualified individual who participates in an approved clinical trial that is conducted outside of Montana.

(4) This section does not require a health insurance issuer offering individual or group health insurance coverage to provide benefits for routine patient costs if the services are provided outside of the network plan offered by the health insurance coverage unless out-of-network benefits are otherwise provided under the coverage.

(5) As used in this section, the following definitions apply:

(a) "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer and is not designed exclusively to test toxicity or disease pathophysiology. The trial must be:

(i) conducted under an investigational new drug application reviewed by the United States food and drug administration;

(ii) exempt from obtaining an investigational new drug application; or

(iii) approved or funded by:

(A) the national institutes of health, the centers for disease control and prevention, the agency for healthcare research and quality, the centers for medicare and medicaid services, or a cooperative group or center of any of the entities described in this subsection (5)(a)(iii)(A);

(B) a cooperative group or center of the United States department of defense or the United States department of veterans affairs;

(C) a qualified nongovernmental research entity identified in the guidelines issued by the national institutes for health for center support groups; or

(D) the United States departments of veterans affairs, defense, or energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States secretary of health and human services to:

(I) be comparable to the system of peer review of studies and investigations used by the national institutes of health; and

(II) provide unbiased scientific review by individuals who have no interest in the outcome of the review.

(b) "Qualified individual" means an individual with health insurance coverage who is eligible to participate in an approved clinical trial according to the trial protocol for the treatment of cancer because:

(i) the referring health care professional is participating in the clinical trial and has concluded that the individual's participation in the trial would be appropriate; or

(ii) the individual provides medical and scientific information establishing that the individual's participation in the clinical trial is appropriate because the individual meets the conditions described in the trial protocol.

(c) (i) "Routine patient costs" include all items and services covered by a plan of individual or group health insurance coverage when the items or services are typically covered for a qualified individual who is not enrolled in an approved clinical trial.

(ii) The term does not include:

(A) an investigational item, device, or service that is part of the trial;

(B) an item or service provided solely to satisfy data collection and analysis needs for the trial if the item or service is not used in the direct clinical management of the patient;

(C) a service that is clearly inconsistent with widely accepted and established standards of care for the individual's diagnosis; or

(D) an item or service customarily provided and paid for by the sponsor of a clinical trial.

History: En. Sec. 1, Ch. 97, L. 2013.

33-22-154. Coverage for refill of eyedrops. (1) Each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage of prescription eyedrops may not deny coverage for a refill of a prescription eyedrop if:

(a) the eyedrop is a covered benefit under the policy, contract, or agreement;

(b) the prescriber indicates on the original prescription that additional quantities are needed;

(c) the refill requested by the insured does not exceed the number of additional quantities needed; and

(d) (i) an amount of time has passed in which the insured should have used 70% of the dosage unit of the drug according to the prescriber's instructions; or

(ii) (A) 21 days have passed since a 30-day supply of the eyedrop was dispensed;

(B) 42 days have passed since a 60-day supply of the eyedrop was dispensed; or

(C) 63 days have passed since a 90-day supply of the eyedrop was dispensed.

(2) (a) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions and to utilization review as provided in Title 33, chapter 32.

(b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage under this section.

History: En. Sec. 1, Ch. 179, L. 2023.

33-22-155. Coverage of contraceptives. (1) Each group or individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state that includes coverage for prescription contraceptives must provide reimbursement for up to a 12-month supply of any covered drug, device, or product for contraception that is prescribed and that has been approved by the U.S. food and drug administration.

(2) The coverage under this section must allow the insured to renew and refill a 12-month prescription a minimum of 60 days before the prescription expires.

(3) The coverage under this section must allow the insured to receive the 12-month supply at one time unless the insured requests less than a 12-month supply or a health care provider specifically prescribes less than a 12-month supply.

(4) If the insured's prescriber recommends a specific contraceptive drug, device, or product approved by the U.S. food and drug administration based on medical necessity, the insurer shall defer to the prescriber's determination and provide coverage for the prescribed contraceptive if the prescribed contraceptive drug, device, or product is covered by the insurer.

(5) Coverage required under this section may not:

(a) in the absence of clinical contraindications, impose utilization controls or other forms of medical management to limit the supply of covered contraceptive drugs, devices, or products that will be reimbursed to less than a 12-month supply;

(b) require prior authorization for coverage of prescription contraceptives, except to review the medical necessity of prescribing a 12-month supply of a brand-name contraceptive instead of a 12-month supply of a generic-name contraceptive;

(c) impose a waiting period for the coverage required under this section; or

(d) impose a special deductible, coinsurance, copayment, or other limitation on prescription contraceptives covered under this section that are not generally applicable to other medical care covered under the plan.

History: En. Sec. 1, Ch. 600, L. 2023.

33-22-156. Health insurance rates — filing required — use. (1) Each health insurance issuer that issues, delivers, or renews individual or small employer group health insurance coverage in the individual or small employer group market shall, at least 60 days before the rate goes into effect, file with the commissioner its rates, fees, dues, and other charges for each product form intended for use in Montana, together with sufficient information to support the premium to be charged as described in 33-22-156 through 33-22-159. This filing may be made simultaneously with a notice of premium increase to policyholders and certificate holders required by 33-22-107.

(2) A health insurance issuer may submit a single combined justification for rate increases subject to review affecting multiple products if the claims experience of all products has been aggregated to calculate the rate increases and the rate increases are the same for all products. Rate increases are determined by combining the total amount of increases taken on a single product form or market segment, if the rate increase is the same for all products, over a 12-month period. A market segment means the individual or small group market.

(3) The commissioner may waive the 60-day filing requirement under subsection (1) if the rate increase is implemented pursuant to 33-22-107(1)(b). However, the rates and justifications for the rate increase still must be filed.

(4) The health insurance issuer shall submit a new filing to reflect any material change to the previous rate filing. For all other changes, the insurer shall submit an amendment to a previous rate filing. The insurer may file an actuarial trend to phase in rate increases over a 12-month period. The insurer may file amendments to that trend within the 12-month period.

(5) The filing of rates for health plans must include:

(a) the product form number or numbers and approval date of the product form or forms to which the rate applies;

(b) a statement of actuarial justification; and

(c) information sufficient to support the rate as described in 33-22-157.

(6) The commissioner shall prescribe the form and content of the information required under this section.

(7) A rate filing required under this section must be submitted by a qualified actuary representing the health insurance issuer. The qualified actuary shall certify in a form prescribed by the commissioner that, to the best of the actuary's knowledge and belief, the rates are not excessive, inadequate, unjustified, or unfairly discriminatory, as described in 33-22-157, and comply with the applicable provisions of Title 33 and rules adopted pursuant to Title 33.

(8) The rate filing must be delivered by the national association of insurance commissioners' system for electronic rate and form filing.

(9) Subject to 33-22-157(4), an insurer may use a rate filing under this section 60 days after the date of filing with the commissioner.

(10) Sections 33-22-156 through 33-22-159 do not apply to coverage consisting solely of excepted benefits as defined in 33-22-140.

History: **En. Sec. 1, Ch. 334, L. 2013; amd. Sec. 22, Ch. 157, L. 2023.**

33-22-157. Standards for review — notice of deficiency. (1) (a) When reviewing a premium rate filing, the commissioner shall consider whether the proposed premium rate is excessive, inadequate, unjustified, or unfairly discriminatory. Rates may be considered excessive if they cause the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage. In order to determine if the rate is excessive, the commissioner shall consider whether:

(i) the assumptions on which the rate increase is based are reasonable; and

(ii) one or more of the assumptions is not supported by the evidence.

(b) Rates may be considered inadequate if the rate is unreasonably low for the coverage provided, and the commissioner may consider if the rate would endanger the solvency of the insurer or disrupt the insurance market in Montana.

(c) A rate increase may be considered unjustified if the health insurance issuer provides data or documentation in connection with the increase that is incomplete, inadequate, or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

(d) Rates may be considered unfairly discriminatory if they violate 33-18-206, 33-22-526, 49-2-309, or other applicable state laws prohibiting discrimination in health insurance.

(2) In order to determine whether the proposed premium rates for health insurance coverage are not excessive, inadequate, unjustified, or unfairly discriminatory, the commissioner may consider:

(a) the health insurance issuer's financial position, including but not limited to surplus, reserves, and investment savings;

(b) historical and projected administrative costs and medical and hospital expenses, including medical trends;

(c) the historical and projected medical loss ratio;

(d) changes to covered benefits or health plan design, along with actuarial projections concerning cost savings or additional expenses related to those changes;

(e) changes in the health insurance issuer's health care cost containment and quality improvement efforts following the health insurance issuer's last rate filing for the same category of health plan;

(f) product development and startup costs, drug and other benefit costs or expenses, and product age and credibility;

(g) whether the proposed change in the premium rate is necessary to maintain the health insurance issuer's solvency or to maintain rate stability and prevent excessive rate increases in the future;

(h) historical and projected claims experience;

(i) trend projections related to utilization and service or unit cost;

(j) allocation of the overall rate increase to claims and nonclaims costs;

(k) allocation of current and projected premium for each enrollee each month;

(l) the 3-year history of rate increases for the product or group of products associated with the rate increase if the product is 3 years old or older and otherwise any available rate history;

(m) employee and executive compensation data from the health insurance issuer's annual financial statements; and

(n) any other applicable information identified in administrative rules adopted pursuant to Title 33, except that the administrative rules may not include by reference any provisions of Public Law 111-148 and Public Law 111-152 or any regulations promulgated under those laws.

(3) The commissioner shall review rate filings and, if applicable, shall provide a notice of deficiencies containing detailed reasons describing why the commissioner finds that the proposed premium rate is excessive, inadequate, unjustified, or unfairly discriminatory. The notice must be provided within 60 days of receipt of filing.

(4) Within 30 days after receiving a notice of deficiencies alleging that a proposed rate is excessive, inadequate, unjustified, or unfairly discriminatory, the insurer may amend its rate filing, request reconsideration based upon additional information, or, unless the rate is unfairly discriminatory pursuant to subsection (1)(d), implement the proposed rate.

(5) At the end of the 30-day period described in subsection (4), if the insurer implements a rate that the commissioner has determined to be excessive, inadequate, or unjustified, the commissioner shall publish the finding on the commissioner's website indicating the commissioner's determination.

History: En. Sec. 2, Ch. 334, L. 2013; amd. Sec. 24, Ch. 151, L. 2017.

33-22-158. Trade secret disclosure exemption. The commissioner, upon request by the health insurance issuer, may exempt from disclosure any part of a premium rate filing submitted pursuant to 33-22-156 that the commissioner determines to contain trade secrets as defined in 30-14-402. The commissioner may not disclose that part of a filing that is subject to a health insurance issuer's request until the commissioner makes a determination under this section. The commissioner shall provide the issuer with 30 days' advance notice of the determination before releasing the information to the public.

History: En. Sec. 3, Ch. 334, L. 2013.

33-22-159. Rulemaking. The commissioner may adopt rules necessary to implement the provisions of 33-22-156 through 33-22-159, except that the administrative rules may not include by reference any provisions of Public Law 111-148 and Public Law 111-152 or any regulations promulgated under those laws.

History: En. Sec. 4, Ch. 334, L. 2013.

33-22-160 through 33-22-165 reserved.

33-22-166. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 1, Ch. 349, L. 2013.

33-22-167 through 33-22-169 reserved.

33-22-170. *(Temporary)* **Definitions.** As used in 33-22-170 through 33-22-177 and 33-22-180, the following definitions apply:

(1) "Contract pharmacy" means a pharmacy operating under contract with a federally certified health entity to provide dispensing services to the federally certified health entity.

(2) "Effective rate contracting" means an agreement or arrangement between a pharmacy or a contracting agent acting on behalf of a pharmacy and a pharmacy benefit manager or third-party payer that establishes a reimbursement rate for pharmaceuticals based on the effective rate of payment rather than on a predetermined fixed price or a fixed discount percentage. An effective rate of payment involves any calculation for which pharmacy reimbursement is based on an aggregation of more than one claim, rather than on a per-claim basis.

(3) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).

(4) "Independent pharmacy" means a pharmacy as defined in 37-7-101 that:

(a) is licensed with the board of pharmacy as a pharmacy;

(b) is located in the state; and

(c) is not owned or operated by or a subsidiary or affiliate of:

(i) a for-profit entity with more than 10 pharmacy locations nationwide;

(ii) a pharmacy benefit manager; or

(iii) a publicly traded entity.

(5) "Maximum allowable cost list" means the list of drugs used by a pharmacy benefit manager that sets the maximum cost on which reimbursement to a network pharmacy or pharmacist is based.

(6) "Pharmacist" means a person licensed by the state to engage in the practice of pharmacy pursuant to Title 37, chapter 7.

(7) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7, and that has entered into a network contract with a pharmacy benefit manager, health insurance issuer, or plan sponsor.

(8) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of a health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies or pharmacists, pay pharmacies or pharmacists for prescription drugs, or provide other prescription drug or device services.

(9) "Pharmacy performance measurement entity" means:

(a) the electronic quality improvement platform for plans and pharmacies; or

(b) an entity approved by the board of pharmacy provided for in 2-15-1733 as a nationally recognized and unbiased entity that assists pharmacies in improving performance measures.

(10) "Pharmacy services administrative organization" means an entity that acts as a contracting agent or provides contracting and other administrative services to pharmacies to assist them in their interactions with third-party payers and pharmacy benefit managers.

(11) "Prescription drug" means any drug that is required by federal law or regulation to be dispensed only by a prescription subject to section 353(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 301 et seq.

(12) "Prescription drug order" has the meaning provided in 37-7-101.

(13) "Reference pricing" means a calculation for the price of a pharmaceutical that uses the most current nationally recognized reference price or amount to set the reimbursement for prescription drugs and other products, supplies, and services covered by a network contract between a plan sponsor, health insurance issuer, or pharmacy benefit manager and a pharmacy or pharmacist. *(Terminates June 30, 2029—sec. 8, Ch. 474, L. 2025.)*

33-22-170. *(Effective July 1, 2029)* **Definitions.** As used in 33-22-170 through 33-22-177 and 33-22-180, the following definitions apply:

(1) "Contract pharmacy" means a pharmacy operating under contract with a federally certified health entity to provide dispensing services to the federally certified health entity.

(2) "Federally certified health entity" means a 340B covered entity as described in 42 U.S.C. 256b(a)(4).

(3) "Maximum allowable cost list" means the list of drugs used by a pharmacy benefit manager that sets the maximum cost on which reimbursement to a network pharmacy or pharmacist is based.

(4) "Pharmacist" means a person licensed by the state to engage in the practice of pharmacy pursuant to Title 37, chapter 7.

(5) "Pharmacy" means an established location, either physical or electronic, that is licensed by the board of pharmacy pursuant to Title 37, chapter 7, and that has entered into a network contract with a pharmacy benefit manager, health insurance issuer, or plan sponsor.

(6) "Pharmacy benefit manager" means a person who contracts with pharmacies on behalf of a health insurance issuer, third-party administrator, or plan sponsor to process claims for prescription drugs, provide retail network management for pharmacies or pharmacists, pay pharmacies or pharmacists for prescription drugs, or provide other prescription drug or device services.

(7) "Pharmacy performance measurement entity" means:

(a) the electronic quality improvement platform for plans and pharmacies; or

(b) an entity approved by the board of pharmacy provided for in 2-15-1733 as a nationally recognized and unbiased entity that assists pharmacies in improving performance measures.

(8) "Pharmacy services administrative organization" means an entity that acts as a contracting agent or provides contracting and other administrative services to pharmacies to assist them in their interactions with third-party payers and pharmacy benefit managers.

(9) "Prescription drug" means any drug that is required by federal law or regulation to be dispensed only by a prescription subject to section 353(b) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 301 et seq.

(10) "Prescription drug order" has the meaning provided in 37-7-101.

(11) "Reference pricing" means a calculation for the price of a pharmaceutical that uses the most current nationally recognized reference price or amount to set the reimbursement for prescription drugs and other products, supplies, and services covered by a network contract between a plan sponsor, health insurance issuer, or pharmacy benefit manager and a pharmacy or pharmacist.

History: En. Sec. 1, Ch. 431, L. 2015; amd. Sec. 1, Ch. 136, L. 2017; amd. Sec. 5, Ch. 88, L. 2019; amd. Sec. 3, Ch. 215, L. 2019; amd. Sec. 15, Ch. 501, L. 2021; amd. Sec. 23, Ch. 157, L. 2023; amd. Sec. 2, Ch. 474, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 2, Ch. 474, L. 2025. Amendment effective October 1, 2025, and terminates June 30, 2029.

Applicability: Section 7, Ch. 474, L. 2025, provided: "[This act] applies to conduct occurring on or after October 1, 2025."

33-22-171. *(Temporary)* **Maximum allowable cost list — limitations on drugs.** Before a pharmacy benefit manager places or continues a drug on a maximum allowable cost list, the drug:

(1) must be listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations or have an "NR" or "NA" rating by a nationally recognized reference;

(2) must be available for purchase by pharmacies in this state from national or regional wholesalers; and

(3) may not be obsolete, temporarily unavailable, or listed on a drug shortage list. *(Terminates June 30, 2029—sec. 8, Ch. 474, L. 2025.)*

33-22-171. *(Effective July 1, 2029)* **Maximum allowable cost list — limitations on drugs.** Before a pharmacy benefit manager places or continues a drug on a maximum allowable cost list, the drug:

(1) must be listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations or have an "NR" or "NA" rating by a nationally recognized reference;

(2) must be available for purchase by pharmacies in this state from national or regional wholesalers; and

(3) may not be obsolete.

History: En. Sec. 2, Ch. 431, L. 2015; amd. Sec. 3, Ch. 474, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 3, Ch. 474, L. 2025. Amendment effective October 1, 2025, and terminates June 30, 2029.

Applicability: Section 7, Ch. 474, L. 2025, provided: "[This act] applies to conduct occurring on or after October 1, 2025."

33-22-172. *(Temporary)* **Maximum allowable cost or reference price list — price formulation, updating, and disclosure — exceptions.** (1) At the time of entering into a contract with a pharmacy or a pharmacy services administrative organization and subsequently upon request, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall provide the pharmacy or pharmacy services administrative organization with the sources used to determine the pricing for the maximum allowable cost list or the reference used for reference pricing.

(2) If using a maximum allowable cost list, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

(a) review and update the price information for each drug on the maximum allowable cost list at least once every 10 calendar days to reflect any modification of pricing, ensuring that maximum allowable cost increases are processed and updated on the same schedule as decreases;

(b) establish a process for eliminating products from the maximum allowable cost list or modifying the prices in the maximum allowable cost list in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and

(c) provide a process for each pharmacy to readily access the maximum allowable cost list specific to the pharmacy in a searchable and usable format.

(3) If using reference pricing, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

(a) review and update not less than every 10 business days the price information for each drug, product, supply, or service for which reference pricing is used, updating reference pricing on the same date of the change in the referenced source; and

(b) provide a process for each pharmacy to readily access the reference pricing specific to the plan sponsor or the health insurance issuer's plan.

(4) A plan sponsor, health insurance issuer, or pharmacy benefit manager may not:

(a) prohibit a pharmacist from discussing reimbursement criteria with a covered person;

(b) penalize a pharmacy or a pharmacist for disclosing the information described in subsection (4)(a) to a covered person or for selling a more affordable alternative to a covered person; or

(c) require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy.

(5) (a) A plan sponsor, pharmacy benefits manager, or third-party payer shall ensure that reimbursement to independent pharmacies for each drug dispensed is not less than the national average drug acquisition cost plus a professional dispensing fee that is not less than the minimum specified in this subsection (5). The national average drug acquisition cost price must be the price published in effect for the day the drug claim was billed by the pharmacy.

(b) In the event that a particular drug does not have a published national average drug acquisition price, the reimbursement to independent pharmacies must be:

(i) for generic drugs, 100% of published wholesale acquisition costs plus a professional dispensing fee that is not less than the minimum specified in this subsection (5); and

(ii) for brand-name drugs, 100% of wholesale acquisition costs plus a professional dispensing fee that is not less than the minimum specified in this subsection (5).

(c) The minimum professional dispensing fee for independent pharmacies is $15, subject to an annual increase. On January 1 of each year, a plan sponsor, pharmacy benefits manager, or third-party payer shall increase the amount of the minimum professional dispensing fee for independent pharmacies for inflation. Inflation is measured by the annual percentage increase, if any, in the consumer price index, U.S. city average, all urban consumers, for all items, as published by the bureau of labor statistics of the United States department of labor.

(d) This subsection (5) does not apply to reimbursements to pharmacies under Title 39, chapter 71. *(Terminates June 30, 2029—sec. 8, Ch. 474, L. 2025.)*

33-22-172. *(Effective July 1, 2029)* **Maximum allowable cost or reference price list — price formulation, updating, and disclosure — exceptions.** (1) At the time of entering into a contract with a pharmacy or a pharmacy services administrative organization and subsequently upon request, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall provide the pharmacy or pharmacy services administrative organization with the sources used to determine the pricing for the maximum allowable cost list or the reference used for reference pricing.

(2) If using a maximum allowable cost list, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

(a) review and update the price information for each drug on the maximum allowable cost list at least once every 10 calendar days to reflect any modification of pricing;

(b) establish a process for eliminating products from the maximum allowable cost list or modifying the prices in the maximum allowable cost list in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and

(c) provide a process for each pharmacy to readily access the maximum allowable cost list specific to the pharmacy in a searchable and usable format.

(3) If using reference pricing, a plan sponsor, health insurance issuer, or pharmacy benefit manager shall:

(a) review and update no less than every 10 business days the price information for each drug, product, supply, or service for which reference pricing is used; and

(b) provide a process for each pharmacy to readily access the reference pricing specific to the plan sponsor or the health insurance issuer's plan.

(4) A plan sponsor, health insurance issuer, or pharmacy benefit manager may not:

(a) prohibit a pharmacist from discussing reimbursement criteria with a covered person;

(b) penalize a pharmacy or a pharmacist for disclosing the information described in subsection (4)(a) to a covered person or for selling a more affordable alternative to a covered person; or

(c) require a pharmacy to charge or collect a copayment from a covered person that exceeds the total charges submitted by the network pharmacy.

History: **En. Sec. 3, Ch. 431, L. 2015; amd. Sec. 2, Ch. 136, L. 2017; amd. Sec. 1, Ch. 263, L. 2019; amd. Sec. 24, Ch. 157, L. 2023; amd. Sec. 4, Ch. 474, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 4, Ch. 474, L. 2025. Amendment effective October 1, 2025, and terminates June 30, 2029.

Applicability: Section 7, Ch. 474, L. 2025, provided: "[This act] applies to conduct occurring on or after October 1, 2025."

33-22-173. Maximum allowable cost — appeals process. (1) In contracting with a pharmacy or a pharmacy services administrative organization, a plan sponsor or pharmacy benefit manager shall:

(a) provide a procedure by which a pharmacy or a pharmacy services administrative organization may appeal the price of a drug or drugs on the maximum allowable cost list;

(b) provide a telephone number at which a network pharmacy may contact the pharmacy benefit manager to discuss the status of the pharmacy's appeal; and

(c) respond to an appeal no later than 10 calendar days after the date the appeal is made.

(2) If the final determination is a denial of the pharmacy's or the pharmacy services administrative organization's appeal, the pharmacy benefit manager shall state the reason for the denial and provide the national drug code of an equivalent drug that is available for purchase by pharmacies in this state from national or regional wholesalers at a price that is equal to or less than the maximum allowable cost for that drug.

(3) If a pharmacy's or a pharmacy services administrative organization's appeal is determined to be valid by the pharmacy benefit manager, the pharmacy benefit manager shall:

(a) make an adjustment in the drug price effective on the date the appeal is resolved;

(b) make the adjustment applicable to all similarly situated network pharmacy providers as determined by the plan sponsor or the pharmacy benefit manager, as appropriate; and

(c) permit the appealing pharmacy to reverse and rebill the claim in question, using the dates of the original claim or claims.

(4) A pharmacy benefit manager shall make price adjustments to all similarly situated pharmacies within 3 days.

(5) A pharmacy or a pharmacy services administrative organization shall file its appeal within 10 calendar days from the time of denial by the pharmacy benefit manager.

History: **En. Sec. 4, Ch. 431, L. 2015; amd. Sec. 25, Ch. 157, L. 2023.**

33-22-174. Opt-out of reference pricing — notification. (1) A pharmacist or pharmacy in a network plan with a plan sponsor, health insurance issuer, or pharmacy benefit manager providing covered drugs on a reference pricing basis may decline to provide a brand-name drug, multisource generic drug, supply, or service if the reference pricing amount is less than the acquisition cost paid by the pharmacy or pharmacist.

(2) If a pharmacist or pharmacy declines to provide the prescription or service under the conditions in subsection (1), the pharmacy or pharmacist shall attempt to provide the customer with adequate information as to where the prescription for the drug, supply, or service may be filled.

(3) A pharmacy or pharmacist who declines to provide the prescription or service as provided in subsection (2) shall cooperate with any investigation and review of network adequacy.

History: **En. Sec. 3, Ch. 136, L. 2017; amd. Sec. 16, Ch. 501, L. 2021.**

33-22-175. *(Temporary)* **Allowable and prohibited fees on pharmacies.** (1) A pharmacy benefit manager, a third-party payer, or a discount card processor may not directly or indirectly charge or hold a pharmacy responsible for a fee, including but not limited to the following:

(a) a fee for submission of a claim;

(b) any other claim-related fee;

(c) a fee for enrollment or participation in a retail pharmacy network;

(d) a credentialing or recredentialing fee;

(e) a fee for the development or management of claims processing services or claims payment services; or

(f) a fee on remittance advice or a fee that is retroactive.

(2) Only criteria established by a pharmacy performance measurement entity may be used to measure a pharmacy's performance for the purposes of this section.

(3) A pharmacy benefits manager or third-party payer may not make or allow any reduction in payment for pharmacy services by a pharmacy benefits manager or third-party payer or directly or indirectly reduce a payment for a pharmacy service under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payments.

(4) All reimbursements to pharmacies must be made through direct bank transfers, checks, or other payment methods that do not incur processing fees for the pharmacy. Checks must have a 180-day expiration to deposit. *(Terminates June 30, 2029—sec. 8, Ch. 474, L. 2025.)*

33-22-175. *(Effective July 1, 2029)* **Allowable and prohibited fees on pharmacies.** (1) A pharmacy benefit manager or third-party payer may not directly or indirectly charge or hold a pharmacy responsible for a fee related to a claim:

(a) if the fee is not apparent at the time the claim is processed;

(b) if the fee is not reported on the remittance advice of an adjudicated claim; or

(c) after the initial claim is adjudicated.

(2) A pharmacy benefit manager or third-party payer may collect a performance-based fee from a pharmacy only if the pharmacy fails to meet the criteria established by a pharmacy performance measurement entity. The fee may be applied only to the professional dispensing fee outlined in the contract with the pharmacy and may not be imposed on the cost of goods sold by a pharmacy.

(3) Only criteria established by a pharmacy performance measurement entity may be used to measure a pharmacy's performance for the purposes of this section.

History: En. Sec. 1, Ch. 88, L. 2019; amd. Sec. 5, Ch. 474, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 5, Ch. 474, L. 2025. Amendment effective October 1, 2025, and terminates June 30, 2029.

Applicability: Section 7, Ch. 474, L. 2025, provided: "[This act] applies to conduct occurring on or after October 1, 2025."

33-22-176. Limitation on copayments. A pharmacy benefit manager or third-party payer may not charge a patient a copayment that exceeds the cost of the prescription drug. If a patient pays a copayment, the dispensing provider or pharmacy may retain the adjudicated reimbursement and the pharmacy benefit manager or third-party payer may not alter the adjudicated reimbursement.

History: En. Sec. 2, Ch. 88, L. 2019.

33-22-177. *(Temporary)* **Rights of pharmacies.** (1) A pharmacy benefit manager or third-party payer may not prohibit a pharmacist or pharmacy from:

(a) participating in a class-action lawsuit;

(b) disclosing to the plan sponsor or to the patient information regarding the adjudicated reimbursement paid to the pharmacy if the pharmacist or pharmacy complies with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1181 et seq.;

(c) providing relevant information to a patient about the patient's prescription drug order, including but not limited to the cost and clinical efficacy of a more affordable alternative drug if one is available;

(d) mailing or delivering a prescription drug to a patient as an ancillary service of a pharmacy if the practice is not prohibited under Title 37, chapter 7; or

(e) charging a shipping and handling fee to a patient who has asked that a prescription drug be mailed or delivered if the practice is not prohibited under Title 37, chapter 7.

(2) A pharmacy benefit manager or third-party payer may not:

(a) require pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state; or

(b) exclude a pharmacy from the pharmacy benefit manager's or third-party payer's network based solely on the pharmacy being newly opened or open less than a defined amount of time, or because a license or location transfer occurs, unless there is a pending investigation for fraud, waste, or abuse.

(3) A pharmacist or pharmacy that belongs to a pharmacy services administrative organization may receive a copy of a contract the pharmacy services administrative organization entered into with a pharmacy benefit manager or third-party payer on the pharmacy's or pharmacist's behalf.

(4) A pharmacy benefit manager or third-party payer shall provide a pharmacy or pharmacist with the processor control number, bank identification number, and group number for each pharmacy network established or administered by a pharmacy benefit manager or third-party payer to enable the pharmacy to make an informed contracting decision.

(5) (a) A pharmacy benefit manager shall:

(i) offer a pharmacy or a pharmacy services administrative organization an opportunity to renew an existing contract every 3 years, at a minimum;

(ii) allow a pharmacy or a pharmacy services administrative organization to terminate a contract upon a 90-day notice to the pharmacy benefit manager;

(iii) ensure pharmacy credentialing applications are processed and that pharmacies are added to applicable networks within 45 calendar days after all needed documentation has been submitted by the pharmacy or the pharmacy services administrative organization; and

(iv) ensure pharmacy ownership changes are processed and that the pharmacy can process prescriptions for applicable networks within 30 calendar days after all needed documentation has been submitted by the pharmacy or the pharmacy services administrative organization.

(b) An addendum or amendment to an existing contract between a pharmacy benefit manager and a pharmacy or a pharmacy services administrative organization is effective only upon signing of the addendum or amendment by both parties.

(6) A pharmacy or a pharmacy services administrative organization has a private right of action to enforce provisions of 33-22-175 through 33-22-177.

(7) Effective rate contracting is prohibited in all agreements between pharmacies or contracting agents acting on behalf of a pharmacy and a pharmacy benefit manager or third-party payer. A pharmacy benefit manager or third-party payer may not enter into any contract that establishes payment for services or medications based on an effective rate of reimbursement. A pharmacy benefit manager or third-party payer found to be in violation of this section is subject to penalties, including but not limited to fines, revocation of licensure, or other disciplinary actions.

(8) A pharmacy benefit manager may not:

(a) reimburse a network pharmacy an amount less than the contract price between the pharmacy benefit manager and the insurer, third-party payer, or the pharmacy services management organization the pharmacy benefit manager has contracted with; or

(b) require or coerce a patient to use a pharmacy that is owned by or affiliated with the pharmacy benefit manager.

(9) A pharmacy benefit manager shall apply the same utilization review, fees, copayments or cost-sharing, days allowance, and other conditions on a covered person when the covered person obtains a prescription drug from a pharmacy that is included in the pharmacy benefit manager's pharmacy network, including mail-order pharmacies and the pharmacy benefit manager's owned, affiliated, or preferred pharmacies.

(10) If a covered person is using a mail-order pharmacy, the pharmacy benefit manager shall allow for dispensing at local network pharmacies under the following circumstances to ensure patient access to prescription drugs:

(a) if the prescription is delayed more than 1 day after the expected delivery date provided by the mail-order pharmacy; or

(b) if the prescription drug arrives in an unusable condition as determined by the patient.

(11) A pharmacy benefit manager may not require the usage of mail order for a patient residing in an area where the U.S. postal service does not provide service delivery to a physical address. *(Terminates June 30, 2029—sec. 8, Ch. 474, L. 2025.)*

33-22-177. *(Effective July 1, 2029)* **Rights of pharmacies.** (1) A pharmacy benefit manager or third-party payer may not prohibit a pharmacist or pharmacy from:

(a) participating in a class-action lawsuit;

(b) disclosing to the plan sponsor or to the patient information regarding the adjudicated reimbursement paid to the pharmacy if the pharmacist or pharmacy complies with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1181 et seq.;

(c) providing relevant information to a patient about the patient's prescription drug order, including but not limited to the cost and clinical efficacy of a more affordable alternative drug if one is available;

(d) mailing or delivering a prescription drug to a patient as an ancillary service of a pharmacy if the practice is not prohibited under Title 37, chapter 7; or

(e) charging a shipping and handling fee to a patient who has asked that a prescription drug be mailed or delivered if the practice is not prohibited under Title 37, chapter 7.

(2) A pharmacy benefit manager or third-party payer may not require pharmacy accreditation standards or recertification requirements inconsistent with, more stringent than, or in addition to federal and state requirements for licensure as a pharmacy in this state.

(3) A pharmacist or pharmacy that belongs to a pharmacy services administrative organization may receive a copy of a contract the pharmacy services administrative organization entered into with a pharmacy benefit manager or third-party payer on the pharmacy's or pharmacist's behalf.

(4) A pharmacy benefit manager or third-party payer shall provide a pharmacy or pharmacist with the processor control number, bank identification number, and group number for each pharmacy network established or administered by a pharmacy benefit manager or third-party payer to enable the pharmacy to make an informed contracting decision.

(5) (a) A pharmacy benefit manager shall:

(i) offer a pharmacy or a pharmacy services administrative organization an opportunity to renew an existing contract every 3 years, at a minimum; and

(ii) allow a pharmacy or a pharmacy services administrative organization to terminate a contract upon a 90-day notice to the pharmacy benefit manager.

(b) An addendum or amendment to an existing contract between a pharmacy benefit manager and a pharmacy or a pharmacy services administrative organization is effective only upon signing of the addendum or amendment by both parties.

(6) A pharmacy or a pharmacy services administrative organization has a private right of action to enforce provisions of 33-22-175 through 33-22-177.

History: En. Sec. 3, Ch. 88, L. 2019; amd. Sec. 26, Ch. 157, L. 2023; amd. Sec. 6, Ch. 474, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 6, Ch. 474, L. 2025. Amendment effective October 1, 2025, and terminates June 30, 2029.

Applicability: Section 7, Ch. 474, L. 2025, provided: "[This act] applies to conduct occurring on or after October 1, 2025."

33-22-178 and 33-22-179 reserved.

33-22-180. Contract coverage — nondiscrimination — penalty. (1) A health insurance issuer, a plan sponsor not subject to the Employee Retirement Income Security Act of 1974, as amended, or a pharmacy benefit manager may not include in a contract with a federally certified health entity provisions that allow:

(a) payment for a prescription drug to the federally certified health entity or a contract pharmacy at less than the state rate determined by surveys used to develop national average drug acquisition costs for the centers for medicare and medicaid services or, if a national average drug acquisition cost has not been calculated, a payment less than the wholesale acquisition cost described in 42 U.S.C. 1395w-3a(c)(6)(B); or

(b) an additional fee or charge or other adjustment that is imposed only on the federally certified health entity or its contract pharmacy. Other adjustments under this subsection (1)(b) include but are not limited to payment of a lower dispensing fee or requiring an add-on payment.

(2) A patient eligible to receive drugs under an agreement covered by 42 U.S.C. 256b may not be discriminated against through conditions imposed on a federally certified health entity or its contract pharmacy through which the patient is eligible to receive drugs.

(3) If a health insurance issuer, plan sponsor not subject to Employee Retirement Income Security Act of 1974, as amended, or a pharmacy benefit manager is found guilty of violating subsection (1) or (2), the insurance commissioner shall impose a fine for each separate entity not to exceed $5,000 for each violation, subject to a maximum fine of no more than $100,000 in any year.

History: **En. Sec. 1, Ch. 215, L. 2019.**

Part 2
Individual Policy Requirements

Part Cross-References

Approval of forms by Commissioner, Title 33, ch. 1, part 5.

Life and disability insurance policy language simplification, 33-15-321 through 33-15-329.

33-22-201. Format and content. An individual policy of disability insurance may not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and complies with the following:

(1) The entire money and other considerations for the policy must be expressed in the policy.

(2) The time when the insurance takes effect and terminates must be expressed in the policy.

(3) The policy may insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age that may not exceed 25 years, and any other person dependent upon the policyholder.

(4) The style, arrangement, and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in lightfaced type of a style in general use, the size of which must be uniform and not less than 10 point with a lowercase, unspaced alphabet length not less than 120 point.

(5) The "text" must include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in 33-22-204 through 33-22-215 and 33-22-221 through 33-22-230, must be printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions", except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) The policy may not contain a provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks or short-rate table filed with the commissioner.

History: **En. Sec. 352, Ch. 286, L. 1959; amd. Sec. 1, Ch. 74, L. 1973; amd. Sec. 1, Ch. 83, L. 1974; R.C.M. 1947, 40-4002(1) thru (3), (5) thru (8); amd. Sec. 1, Ch. 342, L. 1979; amd. Sec. 30, Ch. 451, L. 1993; amd. Sec. 58, Ch. 379, L. 1995; amd. Sec. 3, Ch. 26, L. 2019.**

33-22-202. Required provisions — captions — omissions — substitutions — order. (1) Except as provided in subsection (2), each policy delivered or issued for delivery to any person in this state must contain the provisions specified in 33-22-204 through 33-22-215, as those provisions appear. However, the insurer may, at its option, substitute for one or more of the provisions corresponding provisions of different wording approved by the commissioner and not less favorable in any respect to the insured or the beneficiary. Each provision must be preceded by the applicable caption shown or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) If any provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in a manner that makes the provision contained in the policy consistent with the coverage provided by the policy.

(3) The provisions that are the subject of 33-22-204 through 33-22-215, 33-22-221 through 33-22-230, and 33-22-232 or any corresponding provisions used in accordance with the cited sections must be printed in the consecutive order of the provisions in the sections. However, at the option of the insurer, any provision may appear as a unit in any part of the policy with other provisions to which it may be logically related if the resulting policy is not in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

History: **En. Secs. 353, 378, Ch. 286, L. 1959; R.C.M. 1947, 40-4003, 40-4028; amd. Sec. 26, Ch. 198, L. 1979; amd. Sec. 31, Ch. 451, L. 1993; amd. Sec. 59, Ch. 379, L. 1995; amd. Sec. 4, Ch. 26, L. 2019.**

Cross-References

Hearings by Commissioner, 33-1-701.

Policy language simplification, 33-15-321 through 33-15-329.

33-22-203. Requirement of other jurisdictions — statutes — violation. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of parts 1 through 4 of this chapter and which is prescribed or required by the law of the state or country under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(3) No policy provision which is not subject to parts 1 through 4 of this chapter shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(4) A policy delivered or issued for delivery to any person in this state in violation of parts 1 through 4 of this chapter shall be held valid but shall be construed as provided in parts 1 through 4 of this chapter. When any provision in a policy subject to parts 1 through 4 of this chapter is in conflict with any provision of parts 1 through 4 of this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of parts 1 through 4 of this chapter.

History: **En. Secs. 380, 381, Ch. 286, L. 1959; R.C.M. 1947, 40-4030, 40-4031.**

33-22-204. Entire contract — changes. There shall be a provision as follows:

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions."

History: **En. Sec. 354, Ch. 286, L. 1959; R.C.M. 1947, 40-4004; amd. Sec. 1, Ch. 713, L. 1989.**

Cross-References

Interpretation of instruments, Title 1, ch. 4, part 1.

Interpretation of written contracts — statute of frauds, Title 28, ch. 2, part 9.

33-22-205. Time limit on certain defenses. (1) There shall be a provision as follows:

"Time Limit on Certain Defenses: (1) After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.

(2) No claim for loss incurred or disability (as defined in the policy) commencing after 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."

(2) Policy provision (1) of subsection (1) shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial 2-year period or to limit the application of 33-22-222 through 33-22-226 in the event of misstatement with respect to age or occupation or other insurance.

(3) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue, may contain in lieu of policy provision (1) of subsection (1) the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "Incontestable":

"After this policy has been in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

History: En. Sec. 355, Ch. 286, L. 1959; R.C.M. 1947, 40-4005; amd. Sec. 21, Ch. 303, L. 1981.

33-22-206. Grace period. (1) There must be a provision as follows:

"Grace Period: A grace period of.... (insert a number not less than 7 for weekly premium policies, 10 for monthly premium policies, and 31 for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy must continue in force."

(2) A policy in which the insurer reserves the right to refuse renewal must include the following language at the beginning of the provision contained in subsection (1):

"If the insurer does not deliver to the insured or mail to the insured's last address as shown by the records of the insurer a written notice at least 30 days prior to the premium due date of its intention not to renew this policy beyond the period for which the premium has been accepted."

History: En. Sec. 356, Ch. 286, L. 1959; R.C.M. 1947, 40-4006; amd. Sec. 1222, Ch. 56, L. 2009; amd. Sec. 21, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 21, Ch. 8, L. 2025. Amendment effective October 1, 2025.

Cross-References

Computation of time — which days counted, 1-1-306.

33-22-207. Reinstatement. (1) There shall be a provision as follows:

"Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(2) The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(a) until at least age 50; or

(b) in the case of a policy issued after age 44, for at least 5 years from its date of issue.

History: En. Sec. 357, Ch. 286, L. 1959; R.C.M. 1947, 40-4007; amd. Sec. 1, Ch. 713, L. 1989.

33-22-208. Notice of claim. (1) A policy must contain a provision as follows:

"Notice of Claim: Written notice of claim must be given to the insurer within 6 months after the occurrence or commencement of any loss covered by the policy or as soon after that date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at.... (insert the location of the office that the insurer may designate for the purpose) or to any authorized insurance producer of the insurer, with information sufficient to identify the insured, is considered notice to the insurer."

(2) A policy may allow written notice of a claim to be given to the insurer more than 6 months after the occurrence or commencement of any loss covered by the policy or as soon after that date as is reasonably possible.

(3) In a policy providing a loss-of-time benefit that may be payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the provision in subsection (1):

"Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least 2 years, the insured shall, at least once in every 6 months after having given notice of the claim, give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer must be excluded in applying this provision. Delay in giving the notice may not impair the insured's right to any indemnity that would otherwise have accrued during the period of 6 months preceding the date on which the notice is actually given."

History: En. Sec. 358, Ch. 286, L. 1959; amd. Sec. 1, Ch. 189, L. 1974; R.C.M. 1947, 40-4008; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1223, Ch. 56, L. 2009; amd. Sec. 22, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 22, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-209. Claim forms. There shall be a provision as follows:

"Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made."

History: En. Sec. 359, Ch. 286, L. 1959; R.C.M. 1947, 40-4009.

33-22-210. Proofs of loss. There shall be a provision as follows:

"Proofs of Loss: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required."

History: En. Sec. 360, Ch. 286, L. 1959; R.C.M. 1947, 40-4010.

Cross-References

Requirement for redundant proofs of loss — unfair trade practice, 33-18-201.

33-22-211. Time of payment of claims. There shall be a provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid pursuant to 33-18-232 upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid.... (insert period for payment which must not be less frequently than monthly), and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

History: En. Sec. 361, Ch. 286, L. 1959; R.C.M. 1947, 40-4011; amd. Sec. 5, Ch. 471, L. 2021.

Cross-References

Unfair trade practice — delay caused by requiring multiple proofs of loss, 33-18-201.

Administrative penalty for failure to promptly pay claims, 33-18-231 through 33-18-235.

33-22-212. Payment of claims. (1) There shall be a provision as follows:

"Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

(2) The following provisions, or either of them, may be included with the foregoing provision at the option of the insurer:

"If any indemnity of this policy shall be payable to the estate of the insured or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $.... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person."

History: **En. Sec. 362, Ch. 286, L. 1959; R.C.M. 1947, 40-4012.**

33-22-213. Physical examination and autopsy. There shall be a provision as follows:

"Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law."

History: **En. Sec. 363, Ch. 286, L. 1959; R.C.M. 1947, 40-4013.**

Cross-References

Autopsy — limitations, 50-21-103.

33-22-214. Legal actions. There shall be a provision as follows:

"Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the written proof of loss is required to be furnished."

History: **En. Sec. 364, Ch. 286, L. 1959; R.C.M. 1947, 40-4014.**

33-22-215. Change of beneficiary. (1) There shall be a provision as follows:

"Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy."

(2) The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

History: **En. Sec. 365, Ch. 286, L. 1959; R.C.M. 1947, 40-4015.**

33-22-216. Repealed. Sec. 36, Ch. 451, L. 1993.

History: **En. Sec. 3, Ch. 699, L. 1991.**

33-22-217 through 33-22-220 reserved.

33-22-221. Optional policy provisions — substitutes. Except as provided in 33-22-202(2), a policy delivered or issued for delivery to a person in this state may not contain provisions related to the matters in 33-22-222 through 33-22-230 unless those provisions use words that are the same as those that appear in the applicable section. However, the insurer may, at its option, use in lieu of a repetitious provision a corresponding provision of different wording approved by the commissioner if the different wording is not less favorable in any respect to the insured or the beneficiary. Any provision contained in the policy must be preceded individually by the appropriate caption or, at the option of the insurer, by the appropriate individual or group captions or subcaptions that the commissioner may approve.

History: **En. Sec. 366, Ch. 286, L. 1959; R.C.M. 1947, 40-4016; amd. Sec. 5, Ch. 26, L. 2019.**

Cross-References

Hearings by Commissioner, 33-1-701.

Policy language simplification provisions — exemption for statutory requirements, 33-15-325.

33-22-222. Change of occupation. There may be a provision as follows:

"Change of Occupation: If the insured is injured or contracts sickness after having changed the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to a classified occupation, the insurer will pay only the portion of the indemnities provided in this policy that the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of the proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates must be those that have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued. However, if the filing was not required, then the classification of occupational risk and the premium rates must be those last made effective by the insurer in that state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

History: **En. Sec. 367, Ch. 286, L. 1959; R.C.M. 1947, 40-4017; amd. Sec. 1224, Ch. 56, L. 2009.**

33-22-223. Misstatement of age. There may be a provision as follows:

"Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

History: **En. Sec. 368, Ch. 286, L. 1959; R.C.M. 1947, 40-4018.**

33-22-224. Other insurance in this insurer. (1) There may be a provision as follows:

"Other Insurance in This Insurer: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured are in force concurrently with this policy, making the aggregate indemnity for .... (insert type of coverage or coverages) in excess of $.... (insert maximum limit of indemnity or indemnities), the excess insurance is void and all premiums paid for the excess must be returned to the insured or to the insured's estate."

(2) Instead of the provision in subsection (1), there may be the following:

"Insurance effective at any one time on the insured under a similar policy or policies in this insurer is limited to the one policy elected by the insured, the insured's beneficiary, or the insured's estate, as appropriate, and the insurer will return all premiums paid for all other policies."

History: **En. Sec. 369, Ch. 286, L. 1959; R.C.M. 1947, 40-4019; amd. Sec. 1225, Ch. 56, L. 2009.**

33-22-225. Insurance with other insurers — provision of service or expense incurred basis. (1) There may be a provision as follows:

"Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(2) If the foregoing policy provision is included in a policy which also contains the policy provision set out in 33-22-226, there shall be added to the caption of the foregoing provision the phrase "—Expense Incurred Benefits". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and by hospital or medical service organizations and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage".

History: **En. Sec. 370, Ch. 286, L. 1959; R.C.M. 1947, 40-4020.**

Cross-References

Public assistance — reduction of benefits disallowed, 33-22-113.

33-22-226. Insurance with other insurers — other benefits. (1) There may be a provision as follows:

"Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(2) If the foregoing policy provision is included in a policy which also contains the policy provision set out in 33-22-225, there shall be added to the caption of the foregoing provision the phrase "—Other Benefits". The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the foregoing policy provision with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, whether provided by a governmental agency or otherwise shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the foregoing policy provision no third-party liability coverage shall be included as "other valid coverage".

History: **En. Sec. 371, Ch. 286, L. 1959; R.C.M. 1947, 40-4021.**

33-22-227. Relation of earnings to insurance. (1) There may be a provision as follows:

"Relation of Earnings to Insurance: If the total monthly amount of loss-of-time benefits promised for the same loss under all valid loss-of-time coverage upon the insured, whether payable on a weekly or monthly basis, exceeds the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for the proportionate amount of benefits under this policy that the amount of the monthly earnings or the average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all coverage upon the insured at the time the disability commences and for the return of the part of the premiums paid during the 2 years that exceed the pro rata amount of the premiums for the benefits actually paid under this policy. However, this may not operate to reduce the total monthly amount of benefits payable under all coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in the coverages, whichever is the lesser, and may not operate to reduce benefits other than those payable for loss of time."

(2) The policy provision in subsection (1) may be inserted only in a policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner. The definition must be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada or to any other coverage the inclusion of which may be approved by the commissioner or any combination of coverages. In the absence of a definition, the term may not include any coverage provided for the insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

History: En. Sec. 372, Ch. 286, L. 1959; R.C.M. 1947, 40-4022; amd. Sec. 1226, Ch. 56, L. 2009.

33-22-228. Unpaid premiums. There may be a provision as follows:

"Unpaid Premiums: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom."

History: En. Sec. 373; Ch. 286, L. 1959; R.C.M. 1947, 40-4023.

33-22-229. Conformity with state statutes. There must be a provision or the equivalent thereto as follows:

"Conformity with Montana statutes: The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

History: En. Sec. 374, Ch. 286, L. 1959; R.C.M. 1947, 40-4024; amd. Sec. 10, Ch. 518, L. 1983; amd. Sec. 33, Ch. 798, L. 1991.

33-22-230. Illegal occupation. There may be a provision as follows:

"Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation."

History: En. Sec. 375, Ch. 286, L. 1959; R.C.M. 1947, 40-4025.

Cross-References

Own wrong — no advantage, 1-3-208.

Illegal occupation, 33-22-230.

Felony — definition, 45-2-101.

Effect of homicide on intestate succession, wills, trusts, joint assets, life insurance, and beneficiary designations, 72-2-813.

33-22-231. Repealed. Sec. 6, Ch. 26, L. 2019.

History: En. Sec. 376, Ch. 286, L. 1959; R.C.M. 1947, 40-4026.

33-22-232. Renewal at option of insurer. (1) Except as provided in subsection (2), disability insurance policies, other than accident insurance only policies, in which the insurer reserves the right to refuse renewal must provide the statement in a policy provision, an endorsement, or an attached rider. The statement must provide that, subject to the insurer's right to terminate the policy upon nonpayment of premium when due, the right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on or after and nearest each policy anniversary or, in the case of lapse and reinstatement, at the renewal date occurring on or after and nearest each anniversary of the last reinstatement and that any refusal of renewal must be without prejudice to any claim originating while the policy is in force. The reference to lapse and reinstatement may be omitted at the insurer's option.

(2) Policies conforming to this section are subject to the guaranteed renewability provisions of 33-22-247 or 33-22-524.

History: En. Sec. 377, Ch. 286, L. 1959; R.C.M. 1947, 40-4027; amd. Sec. 22, Ch. 303, L. 1981; amd. Sec. 26, Ch. 271, L. 2009.

33-22-233 through 33-22-240 reserved.

33-22-241. Definitions. As used in 33-22-242 and 33-22-243, unless the context indicates otherwise, the following definitions apply:

(1) "Block of business" means an individual disability insurance policy certificate or contract filed and approved by the commissioner pursuant to 33-1-501 and written and sold by a health care insurer to a defined set of individuals. All individuals covered by the policy or contract are considered to be within the block of business.

(2) "Health care insurer" means a disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society.

(3) (a) "Individual health benefit plan" means any hospital or medical expense policy or certificate, subscriber contract, or contract of insurance provided by a prepaid hospital or medical service plan or health maintenance organization subscriber contract and issued for delivery to an individual.

(b) Individual health benefit plan does not include a self-funded group health plan; a self-funded multiemployer group health plan; a group conversion plan; an insured group health plan; accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical payment insurance.

(4) "Qualifying previous coverage" means benefits or coverage provided under:

(a) medicare or medicaid;

(b) group health insurance or a health benefit plan that provides benefits similar to or exceeding benefits provided under the plan being applied for; or

(c) an individual health benefit plan, including coverage issued by a health maintenance organization, a prepaid hospital or medical care plan, or a fraternal benefit society, that provides benefits similar to or exceeding the plan being applied for.

History: En. Sec. 1, Ch. 527, L. 1995.

33-22-242. Waiver of preexisting condition exclusion — exclusion prohibited. (1) A health care insurer shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services in an individual health benefit plan for the period of time that an individual was previously covered by qualifying previous coverage that provided benefits with respect to those services, if the qualifying previous coverage was continuous to a date not more than 30 days prior to the date of application for new coverage.

(2) A health care insurer that offers individual health insurance coverage to a federally defined eligible individual may not impose a preexisting condition exclusion with respect to that coverage.

History: En. Sec. 2, Ch. 527, L. 1995; amd. Sec. 7, Ch. 416, L. 1997.

33-22-243. Premium increases to be distributed proportionately. (1) A health care insurer may increase the health benefit plan charges for an individual policy, certificate, or contract previously issued by that insurer because of a change in the attained age of the insured. Increases in premium, certificate, or contract charges for individual policies, certificates, or contracts previously issued by that insurer, based on factors other than attained age, must be distributed proportionately across the block of business as defined in 33-22-241.

(2) As used in this section, the following definitions apply:

(a) (i) "Health benefit plan" means a hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract.

(ii) Health benefit plan does not include:

(A) accident-only, credit, dental, vision, specified disease, medicare supplement, long-term care, or disability income insurance;

(B) coverage issued as a supplement to liability insurance, workers' compensation insurance, or similar insurance; or

(C) automobile medical payment insurance.

(b) "Health care insurer" or "insurer" means a disability insurer, a health service corporation, a health maintenance organization, or a fraternal benefit society.

(3) The provisions of Title 33, chapter 1, parts 3 and 7, apply to this section.

History: En. Sec. 3, Ch. 527, L. 1995.

33-22-244. Disclosure standards — individual policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

(f) a description of any preauthorization or other preapproval requirements for medical care; and

(g) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(5) Prior to issuance of an individual disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner.

History: En. Sec. 5, Ch. 527, L. 1995; amd. Sec. 2, Ch. 336, L. 2001; amd. Sec. 2, Ch. 463, L. 2007; amd. Sec. 1, Ch. 207, L. 2009; amd. Sec. 23, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 23, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-245. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 8, Ch. 527, L. 1995; amd. Sec. 1, Ch. 504, L. 1997.

33-22-246. Preexisting conditions relating to individual market. (1) Except as provided in subsection (2), a health insurance issuer offering individual health insurance coverage may not exclude coverage for a preexisting condition unless:

(a) medical advice, diagnosis, care, or treatment was recommended to or received by the participant or beneficiary within the 3 years preceding the effective date of coverage; and

(b) coverage for the condition is excluded for not more than 12 months.

(2) A health insurance issuer offering health insurance coverage may not impose a preexisting condition exclusion on a federally defined eligible individual because of a preexisting condition.

History: En. Sec. 37, Ch. 416, L. 1997.

Cross-References

Preexisting conditions relating to group market, 33-22-514.

33-22-247. Guaranteed renewability of individual health insurance coverage. (1) Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue the coverage in force at the option of the individual.

(2) A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market only if:

(a) the individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not received timely premium payments;

(b) the individual has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of a material fact under the terms of the coverage;

(c) the health insurance issuer is ceasing to offer coverage in the individual market in accordance with this section and applicable state law;

(d) in the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the individual no longer lives, resides, or works in the service area of the health insurance issuer or in an area for which the health insurance issuer is authorized to do business, but only if the coverage is terminated under this subsection (2)(d) uniformly without regard to any health status-related factor of covered individuals; or

(e) in the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, as defined in 33-22-1803, the membership of the individual in the bona fide association ceases, but only if the coverage is terminated under this subsection (2)(e) uniformly without regard to any health status-related factor of a covered individual.

(3) A health insurance issuer may not discontinue offering a particular type of individual health insurance coverage offered in the individual market unless in accordance with applicable state law and unless:

(a) the health insurance issuer gives notice to each covered individual provided coverage of this type in the individual market of the discontinuation at least 90 days prior to the date of the discontinuation of the coverage;

(b) the health insurance issuer offers to each individual in the individual market provided coverage of this type the option to purchase any other individual health coverage currently being offered by the health insurance issuer to individuals in the individual market; and

(c) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subsection (3)(b), the health insurance issuer acts uniformly, without regard to the claims experience of individuals or any health status-related factor of individuals who may become eligible for the coverage.

(4) (a) A health insurance issuer may not discontinue offering all health insurance coverage in the individual market unless in accordance with applicable state law and unless:

(i) the health insurance issuer provides notice of discontinuation to the commissioner and each covered individual at least 180 days prior to the date of the discontinuation of coverage; and

(ii) all health insurance issued or delivered for issuance in Montana in the individual market is discontinued and coverage under the health insurance coverage in the individual market is not renewed.

(b) In the case of a discontinuation under subsection (4)(a) in the individual market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the individual market during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not renewed.

(5) A health insurance issuer may modify upon renewal health insurance coverage for a policy form offered to individuals in the individual market if the modification is consistent with applicable state law and effective on a uniform basis among all individuals with that policy form.

(6) In the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more bona fide associations, references to "individual" under this section include a reference to the bona fide association of which the individual is a member.

History: En. Sec. 38, Ch. 416, L. 1997.

Cross-References

Guaranteed renewability of coverage for employers in group market, 33-22-524.

Guaranteed renewability in multiple employer welfare arrangements, 33-22-525.

33-22-248 through 33-22-260 reserved.

33-22-261. Terminated. Sec. 14, Ch. 325, L. 2003.

History: En. Sec. 1, Ch. 325, L. 2003.

33-22-262. Terminated. Sec. 14, Ch. 325, L. 2003.

History: En. Sec. 2, Ch. 325, L. 2003; amd. Sec. 1, Ch. 174, L. 2005; amd. Sec. 3, Ch. 463, L. 2007.

33-22-263. Terminated. Sec. 14, Ch. 325, L. 2003.

History: En. Sec. 3, Ch. 325, L. 2003.

Part 3

Requirements for Certain Individual Coverages

33-22-301. Coverage of newborn under disability policy. (1) Each policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) The coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) A policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days.

History: (1), (2)En. 40-4002.1 by Sec. 2, Ch. 74, L. 1973; amd. Sec. 2, Ch. 83, L. 1974; Sec. 40-4002.1, R.C.M. 1947; (3)En. Sec. 352, Ch. 286, L. 1959; amd. Sec. 1, Ch. 74, L. 1973; amd. Sec. 1, Ch. 83, L. 1974; Sec. 40-4002, R.C.M. 1947; R.C.M. 1947, 40-4002.1, 40-4002(4); (4)En. Sec. 23, Ch. 303, L. 1981; amd. Sec. 4, Ch. 139, L. 1987; amd. Sec. 60, Ch. 379, L. 1995; amd. Sec. 4, Ch. 325, L. 2003; amd. Sec. 25, Ch. 151, L. 2017.

Cross-References

Child support enforced by Department of Public Health and Human Services — insurance coverage required, 40-5-208.

33-22-302. Age limits — effect on coverage. (1) (a) Except as provided in subsection (1)(b), if any disability policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and if that date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted.

(b) Policies conforming to subsection (1)(a) are subject to the guaranteed renewability provisions of 33-22-247 or 33-22-524.

(2) In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer is limited to the refund, upon request, of all premium or premiums paid for the period not covered by the policy.

History: En. Sec. 382, Ch. 286, L. 1959; R.C.M. 1947, 40-4032; amd. Sec. 27, Ch. 271, L. 2009.

33-22-303. Coverage for well-child care. (1) Each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, accident-only, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(b) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state.

History: En. Sec. 1, Ch. 199, L. 1991; amd. Sec. 61, Ch. 379, L. 1995; amd. Sec. 39, Ch. 380, L. 2003; amd. Sec. 2, Ch. 390, L. 2007.

33-22-304. Continuation of coverage for individuals with disabilities — individual contracts. (1) An individual hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state that provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the policy or contract must also provide in substance that attainment of the limiting age may not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical disability and chiefly dependent upon the policyholder or subscriber for support and maintenance. Proof of intellectual disability or physical disability and dependency must be furnished to the insurer or hospital or medical service plan corporation by the policyholder or subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation. Proof may not be required more frequently than annually after the 2-year period following the child's attainment of the limiting age.

(2) Notwithstanding any other exemption or contrary law, the provisions of this section have equal application to hospital or medical expense insurance policies and hospital and medical service plan contracts.

History: (1)En. 40-3738 by Sec. 1, Ch. 298, L. 1971; Sec. 40-3738, R.C.M. 1947; (2)En. Sec. 2, Ch. 298, L. 1971; Sec. 40-3740, R.C.M. 1947; R.C.M. 1947, 40-3738, 40-3740; amd. Sec. 22, Ch. 472, L. 1997; amd. Sec. 2, Ch. 68, L. 2013.

33-22-305. Short title. Sections 33-22-305 through 33-22-311 may be cited as the "Individual Family Disability Insurance Continuity of Coverage Act".

History: En. Sec. 1, Ch. 245, L. 1981.

33-22-306. Purpose. The purpose of 33-22-305 through 33-22-311 is to provide for the right of covered family members under individual family disability insurance policies to continuity of coverage upon the death of the named insured, the divorce, annulment of marriage, or legal separation of the spouse from the named insured, or any other condition specifically stated in such disability insurance policies under which coverage would otherwise terminate as to the covered spouse or covered dependent children of the named insured.

History: En. Sec. 2, Ch. 245, L. 1981.

33-22-307. Continuity of coverage. (1) Subject to the requirements of 33-22-305 through 33-22-311 and on the date specified in the policy under which coverage otherwise terminates because of the death of the named insured or for any other reason specified in 33-22-306, as to covered family members, other than for nonpayment of premium, nonrenewal of the policy, or the expiration of the term for which the policy is issued, a covered person, other than one eligible for medicare or any other similar federal or state disability insurance program, including the spouse and any covered dependent child of the last-named insured or the representative of the child, has the right to continuation of coverage under provisions that, at the option of the carrier, are consistent with:

(a) the continuation of the policy, with the person exercising the right of continuation designated as the named insured;

(b) the issuance of a converted policy with the person exercising the conversion right designated as the named insured; or

(c) both (1)(a) and (1)(b).

(2) When continuation of coverage or conversion is made in the name of the spouse of the named insured, the coverage may, at the option of the spouse, include covered dependent children for whom the spouse has the responsibility for care and support.

History: **En. Sec. 3, Ch. 245, L. 1981; amd. Sec. 43, Ch. 472, L. 1999.**

33-22-308. Form of coverage — requirements — evidence of insurability — preexisting conditions. (1) Coverage continued through the issuance of a converted policy shall consist of the form of coverage then being offered by the carrier as a conversion policy in the jurisdiction where the person exercising the conversion right resides that most nearly approximates the coverage of the policy from which conversion is exercised. Continued and converted coverages, other than those provided through the exercise of continuation or conversion rights contained in optionally renewable or limited right of renewal contracts, must contain:

(a) provisions allowing the person exercising the continuation or conversion the right to renew the coverage until the attainment of the age of eligibility for medicare or any other similar federal or state disability insurance program, subject to the right of the carrier to nonrenew all such policies in this state as a class; or

(b) other renewal provisions that are not less favorable to the insured than those contained in the policy from which conversion is exercised.

(2) Coverage provided through continuation or conversion may not require additional evidence of insurability except as to overinsurance and may not impose any preexisting condition limitations or other contractual time limitations other than those remaining unexpired under the policy or contract from which continuation or conversion is exercised.

History: **En. Sec. 4, Ch. 245, L. 1981.**

33-22-309. Notice. The eligible covered family member exercising the continuation or conversion right must notify the carrier and make payment of the applicable premium within 31 days following the date such coverage otherwise terminates as specified in the policy or contract from which continuation or conversion is being exercised.

History: **En. Sec. 5, Ch. 245, L. 1981.**

33-22-310. Nonduplication. Benefits otherwise payable under a converted policy may be reduced:

(1) so they are not, during the first policy year of the converted policy, in excess of those benefits that would have been payable had the coverage under the policy from which conversion is exercised not terminated; and

(2) by the amount of benefits, if any, payable as to the same loss under the policy from which conversion is exercised.

History: **En. Sec. 6, Ch. 245, L. 1981.**

33-22-311. Overinsurance. The carrier is not required to issue a converted policy if at the time of application the applicant:

(1) (a) has coverage under other disability insurance policies, health service corporation contracts, or self-insured health benefit plans providing similar benefits;

(b) is eligible for coverage under a group policy or contract providing similar benefits;

(c) is provided with similar benefits required by any statute; or

(d) is covered under any national, state, or governmental plan; and

(2) has coverage under subsection (1) that, together with the converted policy, would result in overinsurance according to the carrier's underwriting standards.

History: **En. Sec. 7, Ch. 245, L. 1981.**

33-22-312. Limitations on cost sharing for insulin. (1) Each individual policy of disability insurance or certificate issued that contains coverage for prescription drugs must limit the insured's required copayment or other cost-sharing requirement to $35 for up to a 30-day supply of insulin, regardless of the amount or type of insulin prescribed.

(2) The limitation in this section applies to insulin covered by the insurer's formulary.

(3) Coverage of insulin prescribed for an insured is not subject to a deductible. Cost-sharing amounts paid by the insured for insulin must be counted toward the insured's deductible.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

History: **En. Sec. 1, Ch. 463, L. 2023.**

33-22-313 through 33-22-315 reserved.

33-22-316. Coverage for self-management training and education for treatment of diabetes. (1) Each individual policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for outpatient self-management training and education for the treatment of diabetes. Any education must be provided by a licensed health care professional with expertise in diabetes.

(2) (a) Coverage must include an annual benefit for medically necessary and prescribed outpatient self-management training and education for the treatment of diabetes. At a minimum, the benefit must consist of:

(i) 20 visits of training and education in diabetes self-management in either an individual or group setting within the first year of diagnosis if the insured has not received the training and education previously; and

(ii) 12 visits of followup diabetes self-management training and education services in subsequent years for an insured who has previously received and exhausted the initial 20 visits of education under subsection (2)(a)(i).

(b) Nothing in subsection (2)(a) prohibits an insurer from providing a greater benefit.

(c) For the purposes of this subsection (2), the term "visit" refers to a period of 30 minutes.

(3) Annual copayment and deductible provisions are subject to the same terms and conditions applicable to all other covered benefits within a given policy.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

History: **En. Sec. 1, Ch. 520, L. 2023.**

Part 4
Franchise Disability Insurance
(Repealed)

33-22-401. Repealed. Sec. 1, Ch. 143, L. 2009.

History: **En. Sec. 383, Ch. 286, L. 1959; R.C.M. 1947, 40-4033.**

Part 5
Group Disability Insurance

33-22-501. Group disability insurance defined — eligible groups. Group disability insurance is that form of disability insurance covering groups of persons as defined in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of the groups of persons and issued upon the following bases:

(1) under a policy issued to an employer or trustees of a fund established by an employer, who must be considered the policyholder, insuring employees of the employer for the benefit of persons other than the employer. The term "employees" as used in this subsection includes the officers, managers, and employees of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees

of subsidiary or affiliated corporations, the individual proprietors, partners, and employees of individuals and firms, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise. The term "employees" as used in this subsection may include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" includes elected or appointed officials. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(2) under a policy issued to an association, including a labor union, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance or of insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employees" as used in this subsection may include retired employees.

(3) under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in subsection (2), in which the trustees are considered the policyholder, to insure employees of the employers or members of the unions or of the association or employees of members of the association for the benefit of persons other than the employers or the unions or the association. The term "employees" as used in this subsection may include the officers, managers, and employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employees" as used in this subsection may include retired employees. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(4) under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under a group life policy;

(5) under a policy issued to a voluntary purchasing pool or to the member employers of a voluntary purchasing pool that is formed solely for the purpose of obtaining insurance as provided in 33-22-1815;

(6) under a policy issued to cover any other substantially similar group that, in the discretion of the commissioner, may be subject to the issuance of a group disability policy or contract.

History: En. Sec. 385, Ch. 286, L. 1959; amd. Sec. 3, Ch. 74, L. 1973; amd. Sec. 3, Ch. 83, L. 1974; R.C.M. 1947, 40-4101(intro.), (1) thru (5); amd. Sec. 1, Ch. 375, L. 1995.

Cross-References

Hearings by Commissioner, 33-1-701.

Groups eligible for group life insurance, Title 33, ch. 20, part 11.

33-22-502. Required provisions of group policies. Each group disability insurance policy delivered or issued for delivery in this state must contain in substance the following provisions:

(1) a provision that, in the absence of fraud, all statements made by applicants or the policyholder or by an insured person must be considered representations and not warranties and that a statement made for the purpose of effecting insurance may not avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the insured person or the insured person's beneficiary;

(2) a provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member and to whom benefits are payable. If dependents are included in the coverage, only one certificate is required to be issued for each family unit.

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy;

(4) a provision or the equivalent that reads:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

History: En. Sec. 386, Ch. 286, L. 1959; amd. Sec. 4, Ch. 74, L. 1973; amd. Sec. 4, Ch. 83, L. 1974; R.C.M. 1947, 40-4102(part); amd. Sec. 11, Ch. 798, L. 1991; amd. Sec. 1227, Ch. 56, L. 2009.

Cross-References

Representations not warranties — standard application construction, 33-15-403.

33-22-503. Continuation of benefits to dependents. Any group disability policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group.

History: En. Sec. 385, Ch. 286, L. 1959; amd. Sec. 3, Ch. 74, L. 1973; amd. Sec. 3, Ch. 83, L. 1974; R.C.M. 1947, 40-4101(6).

33-22-504. Newborn infant coverage. (1) A group disability policy or certificate of insurance delivered or issued for delivery in this state may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of persons covered under the policy from and after the moment of birth.

(2) A policy or certificate subject to this section, must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any person covered under the policy.

(3) The coverage for newborn infants must be the same as provided by the policy for other covered persons. However, for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(4) This section does not apply to medicare supplement policies issued by reason of age.

(5) When a group disability policy or certificate issued under the policy provides for coverage or benefits for a resident of this state, the policy or certificate is considered delivered in this state within the meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this state.

(6) The policy or certificate may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days.

History: En. Secs. 385, 386, Ch. 286, L. 1959; amd. Secs. 3, 4, Ch. 74, L. 1973; amd. Secs. 3, 4, Ch. 83, L. 1974; R.C.M. 1947, 40-4101(7), 40-4102(part); amd. Sec. 1, Ch. 384, L. 1987; amd. Sec. 62, Ch. 379, L. 1995; amd. Sec. 8, Ch. 416, L. 1997.

Cross-References

Child support enforced by Department of Public Health and Human Services — insurance coverage required, 40-5-208.

33-22-505. Direct payment of hospital and medical services. Any group disability policy may on request by the group policyholder provide that all or any portion of any indemnities provided by any such policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person. Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

History: En. Sec. 387, Ch. 286, L. 1959; R.C.M. 1947, 40-4103.

33-22-506. Continuation of coverage for persons with disabilities — group contracts. (1) A group hospital or medical expense insurance policy or hospital or medical service plan contract delivered or issued for delivery in this state that provides that coverage of a dependent child of an employee or other member of the covered group terminates upon attainment of the limiting age for dependent children specified in the policy or contract must also provide in substance that attainment of the limiting age may not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical disability and chiefly dependent upon the employee or member for support and maintenance. Proof of intellectual disability or physical disability and dependency must be furnished to the insurer or hospital or medical service plan corporation by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or corporation. Proof may not be required more frequently than annually after the 2-year period following the child's attainment of the limiting age.

(2) Notwithstanding any other exemption or contrary law, the provisions of this section have equal application to hospital or medical expense insurance policies and hospital and medical service plan contracts.

History: (1)En. 40-3739 by Sec. 1, Ch. 298, L. 1971; Sec. 40-3739, R.C.M. 1947; (2)En. Sec. 2, Ch. 298, L. 1971; Sec. 40-3740, R.C.M. 1947; R.C.M. 1947, 40-3739, 40-3740; amd. Sec. 23, Ch. 472, L. 1997; amd. Sec. 3, Ch. 68, L. 2013.

33-22-507. Continuing group coverage after reduction of work schedule. A person covered by a group disability insurance policy issued or renewed after October 1, 1981, under 33-22-501(1) may, for a period of 1 year, with the consent of the employer or the trustees, continue coverage under group disability policy during the person's employment notwithstanding any reduction of the person's regular work schedule to less than the minimum time required to qualify for membership in the group, and the premium charged the person must be equal to that charged other members of the group of the same risk class.

History: En. Sec. 3, Ch. 579, L. 1981; amd. Sec. 1228, Ch. 56, L. 2009.

33-22-508. Conversion on termination of eligibility. (1) A group disability insurance policy or certificate of insurance must contain a provision that if the insurance or any portion of the insurance on a person or the person's dependents or family members covered under the policy ceases because of termination of the person's membership in a group eligible for coverage under the policy, because of termination of the person's employment, as a result of a person's employer discontinuing the employer's business, or as a result of a person's employer discontinuing the group disability insurance policy and not providing for any other group disability insurance or plan and if the person had been insured for a period of 3 months and is not insured under another major medical disability insurance policy or plan, the person is entitled to have issued to the person by the insurer, without evidence of insurability, group disability coverage or an individual disability policy or, in the absence of an individual disability policy issued by the insurer, a group disability policy issued by the insurer on the person or on the person's dependents or family members if application for the individual policy is made and the first premium tendered to the insurer within 31 days after the termination of the group coverage.

(2) A group insurer may meet the requirements of this section by contracting with another insurer to issue conversion policies as described in subsections (5) and (6). The conversion carrier must be authorized to act as an insurer in this state, and the commissioner shall approve the conversion policies pursuant to 33-1-501.

(3) The individual policy or group policy, at the option of the insured, may be on any form then customarily issued by the insurer to individual or group policyholders, with the exception of a policy the eligibility for which is determined by affiliation other than by employment with a common entity. In addition, the insurer or conversion carrier shall make available a conversion policy as required by subsection (6).

(4) The premium for the individual policy or group policy must be at no more than 200% of the insurer's customary rate applicable to the group policy being terminated at the time of the conversion. If the person entitled to conversion under this section has been insured for more than 3 years, the premium may not be more than 150% of the customary rate of the policy being terminated at the time of the conversion. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(5) A conversion carrier shall offer an individual or group conversion policy that provides the same schedule of benefits and covers the same eligible expenses as those being terminated. The premium for the policy must be calculated as described in subsection (4).

(6) The insurer or conversion carrier shall also make available a conversion policy, certificate, or membership contract that provides at least the level of benefits provided by the insurer's lowest cost basic health benefit plan, as defined in 33-22-1803. The conversion rate may not exceed 150% of the highest rate charged for that plan. This subsection does not apply to disability plans that provide only excepted benefits as defined in 33-22-140.

(7) The effective date and time of the conversion policy must be established to ensure that there is no break in coverage between the termination of the group policy coverage and the inception of the conversion policy.

History: En. Sec. 4, Ch. 579, L. 1981; amd. Sec. 2, Ch. 384, L. 1987; amd. Sec. 1, Ch. 200, L. 1991; amd. Sec. 9, Ch. 699, L. 1991; amd. Sec. 63, Ch. 379, L. 1995; amd. Sec. 11, Ch. 527, L. 1995; amd. Sec. 30, Ch. 531, L. 1997; amd. Sec. 1, Ch. 228, L. 1999; amd. Sec. 54, Ch. 227, L. 2001; amd. Sec. 28, Ch. 469, L. 2005; amd. Sec. 13, Ch. 227, L. 2011.

Cross-References

State employee plan — conversion requirement, 2-18-704.

33-22-509. Preexisting conditions. The converted policy may not exclude, as a preexisting condition, any conditions covered by the group contract, including pregnancy of the insured or the insured's spouse or dependents covered by the group contract at the time of conversion.

History: En. Sec. 7, Ch. 579, L. 1981; amd. Sec. 3, Ch. 384, L. 1987.

33-22-510. Insured's family — conversion entitlement. Subject to the conditions set forth in this section, the conversion privilege is also available:

(1) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and children whose coverage under the group policy terminates by reason of the death, otherwise to each surviving child whose coverage under the group policy terminates by reason of the death, or if the group policy provides for continuation of dependent's coverage following the employee's or member's death, at the end of the continuation;

(2) to the spouse of the employee or member upon termination of coverage of the spouse, by reason of ceasing to be a qualified family member under the group policy, while the employee or member remains under the group policy, including children whose coverage under the group policy terminates at the same time; or

(3) to a child solely with respect to the child upon termination of child's coverage by reason of ceasing to be a qualified family member under the group policy if a conversion privilege is not otherwise provided in this section with respect to the termination.

History: En. Sec. 8, Ch. 579, L. 1981; amd. Sec. 1229, Ch. 56, L. 2009.

Cross-References

State employee plan — conversion requirement, 2-18-704.

33-22-511. Applicability. Notwithstanding any provision of Title 33 or other law to the contrary, it shall be lawful for an insurer and insured to agree to any terms in an insurance contract that provides more favorable terms for the benefit of the insured than authorized in Title 33 or other provisions of law.

History: En. Sec. 9, Ch. 579, L. 1981.

33-22-512. Coverage for well-child care. (1) Each group disability policy or certificate of insurance that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, accident-only, medicare supplement, or hospital indemnity policies or certificates.

(5) For purposes of this section:

(a) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(b) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician.

(6) When a group disability policy or certificate of insurance issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state.

History: **En. Sec. 2, Ch. 199, L. 1991; amd. Sec. 40, Ch. 380, L. 2003; amd. Sec. 3, Ch. 390, L. 2007.**

33-22-513. Limitation of eligibility on conversion. An individual who purchases a policy of insurance under 33-22-508 ceases to be eligible for a conversion policy if the individual insured by the policy:

(1) fails to pay the premium on the policy purchased under 33-22-508; or

(2) enrolls under another major medical disability insurance policy or plan, except that the individual may maintain the conversion policy during any waiting period established under any new disability insurance policy or plan that the insured individual purchases.

History: **En. Sec. 3, Ch. 200, L. 1991; amd. Sec. 15, Ch. 399, L. 2007.**

33-22-514. Preexisting conditions relating to group market. (1) A group health plan or a health insurance issuer offering group health insurance coverage may not exclude coverage for a preexisting condition unless:

(a) medical advice, diagnosis, care, or treatment was recommended or received by the participant or beneficiary within the 6-month period ending on the enrollment date;

(b) exclusion of coverage extends for a period of not more than 12 months or 18 months in the case of a late enrollee; and

(c) the period of the preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

(2) Genetic information may not be excluded as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information.

(3) Pregnancy may not be excluded as a preexisting condition.

History: **En. Sec. 39, Ch. 416, L. 1997; amd. Sec. 44, Ch. 472, L. 1999.**

Cross-References

Preexisting conditions relating to individual market, 33-22-246.

33-22-515. Coverage of autism spectrum disorders. (1) Each group disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger.

(2) Coverage under this section must be provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

(a) autistic disorder;

(b) Asperger's disorder; or

(c) pervasive developmental disorder not otherwise specified.

(3) (a) Coverage under this section must include:

(i) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;

(ii) medications prescribed by a physician licensed under Title 37, chapter 3;

(iii) psychiatric or psychological care; and

(iv) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

(b) (i) Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

(ii) Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the department of public health and human services as a family support specialist with an autism endorsement.

(4) (a) Coverage for treatment of autism spectrum disorders under this section may be limited to a maximum benefit of:

(i) $50,000 a year for a child 8 years of age or younger; and

(ii) $20,000 a year for a child 9 years of age through 18 years of age.

(b) Benefits provided under this section may not be construed as limiting physical health benefits that are otherwise available to the covered child.

(5) (a) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions.

(b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other medical care covered under the plan may not be imposed on the coverage for autism spectrum disorders provided for under this section.

(6) When treatment is expected to require continued services, the insurer may request that the treating physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is medically necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may ask that the treatment plan be updated every 6 months.

(7) As used in this section, "medically necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to:

(a) prevent the onset of an illness, condition, injury, or disability;

(b) reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or

(c) assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

(8) This section applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, school district, or other political subdivision of this state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.

(9) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.

History: En. Sec. 1, Ch. 359, L. 2009.

33-22-516 through 33-22-520 reserved.

33-22-521. Disclosure standards — group policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

(f) a description of any preauthorization or other preapproval requirements for medical care; and

(g) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(6) An outline of coverage must also be sent to an employee when an employee is sent a certificate of insurance.

(7) Prior to issuance of a group disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner.

History: **En. Sec. 6, Ch. 527, L. 1995; amd. Sec. 3, Ch. 336, L. 2001; amd. Sec. 4, Ch. 463, L. 2007; amd. Sec. 2, Ch. 207, L. 2009; amd. Sec. 24, Ch. 8, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 24, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-522. Repealed. Sec. 22, Ch. 169, L. 2013.

History: **En. Sec. 9, Ch. 527, L. 1995; amd. Sec. 2, Ch. 504, L. 1997.**

33-22-523. Special enrollment periods. (1) A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee or a dependent of an employee who is eligible, but not enrolled, for coverage under the terms of the group health plan to enroll for coverage under the terms of the group health plan if:

(a) the employee or dependent was covered under a group health plan or had health insurance coverage at the time that coverage was previously offered to the employee or dependent;

(b) the employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time;

(c) the employee's or dependent's coverage described in subsection (1)(a) was:

(i) under a COBRA continuation provision and was exhausted; or

(ii) not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage or because employer contributions toward the coverage were terminated; and

(d) under the terms of the group health plan, the employee requests the enrollment not later than 30 days after the date of exhaustion of coverage described in subsection (1)(c)(i) or termination of coverage or employer contribution described in subsection (1)(c)(ii).

(2) (a) A group health plan must provide for a dependent special enrollment period described in subsection (2)(b) during which a dependent may be enrolled under the group health plan as a dependent of the individual if the person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption. In the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period under this subsection (2) is a period of not less than 30 days that begins on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, adoption, or placement for adoption.

(3) If an individual seeks to enroll a dependent during the first 30 days of the dependent special enrollment period, the coverage of the dependent becomes effective:

(a) in the case of marriage, not later than the first day of the first month beginning after the date on which the completed request for enrollment is received;

(b) in the case of a dependent's birth, as of the date of birth; or

(c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

History: En. Sec. 35, Ch. 416, L. 1997; amd. Sec. 45, Ch. 472, L. 1999.

33-22-524. Guaranteed renewability of coverage for employers in group market. (1) Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small group market or large group market in connection with a group health plan, the health insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor.

(2) A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small group market or large group market if:

(a) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not received timely premium payments;

(b) the plan sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage;

(c) the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group health plan participation rules;

(d) the health insurance issuer is ceasing to offer coverage in that group market in accordance with this section and applicable state law;

(e) in the case of a health insurance issuer that offers health insurance coverage in the group market through a network plan, there is no longer any enrollee in connection with the group health plan who lives, resides, or works in the service area of the health insurance issuer and, in the case of the small group market, if the health insurance issuer would deny enrollment with respect to the plan under 33-22-1811(4)(a)(i); or

(f) in the case of health insurance coverage that is made available in the small group market or large group market only through one or more bona fide associations, the membership of an employer in the bona fide association ceases, but only if the coverage is terminated under this subsection (2)(f) uniformly without regard to any health status-related factor of a covered individual.

(3) A health insurance issuer may not discontinue offering a particular type of group health insurance coverage offered in the small group market or large group market unless in accordance with applicable state law and unless:

(a) the issuer provides notice to each plan sponsor, participant, and beneficiary provided coverage of this type in that group market of the discontinuation at least 90 days prior to the date of the discontinuation of the coverage;

(b) the issuer offers to each plan sponsor provided coverage of this type in the market the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in the market; and

(c) the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor of any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(4) (a) A health insurance issuer may not discontinue offering all health insurance coverage in the small group market, the large group market, or both the small group market and the large group market, unless in accordance with applicable state law and unless:

(i) the issuer provides notice of discontinuation to the commissioner and to each plan sponsor, participant, and beneficiary covered at least 180 days prior to the date of the discontinuation of coverage; and

(ii) all health insurance issued or delivered for issuance in Montana in the group market or markets is discontinued and coverage under the health insurance coverage in the group market or markets is not renewed.

(b) In the case of a discontinuation under this section in a group market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the group market for a period of 5 years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

(5) A health insurance issuer may modify upon renewal health insurance coverage for a product offered to a group health plan in the large group market or in the small group market if, for coverage that is available in the small group market other than only through one or more bona fide associations, modification is consistent with applicable state law and effective on a uniform basis among group health plans with that product.

(6) In the case of health insurance coverage that is made available by a health insurance issuer in the small group market or large group market to employers only through one or more bona fide associations, references to "plan sponsor" under this section include those employers.

History: **En. Sec. 40, Ch. 416, L. 1997; amd. Sec. 46, Ch. 472, L. 1999.**

Cross-References

Guaranteed renewability of individual health insurance coverage, 33-22-247.
Guaranteed renewability in multiple employer welfare arrangements, 33-22-525.

33-22-525. Guaranteed renewability in multiple employer welfare arrangements. A group health plan that is a multiple employer welfare arrangement, as defined by 29 U.S.C. 1002, may not deny an employer whose employees are covered under the group health plan continued access to the same or different coverage under the terms of the group health plan other than:

(1) for nonpayment of contributions;

(2) for fraud or other intentional misrepresentation of material fact by the employer;

(3) for noncompliance with material plan provisions;

(4) because the group health plan is ceasing to offer any coverage in a geographic area;

(5) in the case of a group health plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the group health plan applies to this section uniformly without regard to the claims experience of employers or any health status-related factor of those individuals or their dependents; or

(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the group health plan, or to employ employees covered by the agreement.

History: **En. Sec. 42, Ch. 416, L. 1997.**

Cross-References

Guaranteed renewability of individual health insurance coverage, 33-22-247.
Guaranteed renewability of coverage for employers in group market, 33-22-524.
Multiple employer welfare arrangements, Title 33, ch. 35.

33-22-526. Group health discrimination prohibited. (1) (a) A group health plan or a health insurance issuer offering group health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based on any of the following health status-related factors of the individual or a dependent of the individual:

(i) health status;

(ii) medical condition, including both physical and mental illnesses;

(iii) claims experience;

(iv) receipt of health care;

(v) medical history;

(vi) genetic information;

(vii) evidence of insurability, including conditions arising out of acts of domestic violence; or

(viii) disability.

(b) This subsection does not:

(i) require a group health plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the group health plan or group health insurance coverage; or

(ii) prevent the group health plan or group health insurance coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the group health plan or group health insurance coverage.

(c) For purposes of subsection (1)(a), rules for eligibility to enroll under a group health plan include rules defining an applicable waiting period for the enrollment.

(2) (a) A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan may not require an individual, as a condition of enrollment or continued enrollment under the group health plan, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the group health plan on the basis of any health status-related factor of the individual or of an individual enrolled under the plan as a dependent of the individual.

(b) This subsection (2) does not:

(i) restrict the amount that an employer may be charged for coverage under a group health plan; or

(ii) prevent a group health plan and a health insurance issuer offering group health insurance coverage from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

History: **En. Sec. 44, Ch. 416, L. 1997.**

Cross-References

Illegal discrimination, Title 49, ch. 2.

33-22-527 through 33-22-529 reserved.

33-22-530. Notice required for cancellation for nonpayment of group health insurance. (1) A health insurance issuer shall provide at least 15 days prior notification of cancellation for nonpayment of premium for group health insurance coverage.

(2) The notice must be sent to the policyholder at the policyholder's last-known address and must specify the date of cancellation of coverage. The insurer shall attach a properly executed proof of mailing to this notice and maintain a copy of the proof of mailing in its records.

(3) The health insurance issuer shall hold for processing of payment any claims for covered benefits incurred during the 15-day notification period for nonpayment of premium for group health insurance coverage. Upon receipt of the premium, claims held for the 15-day notification period must be processed for payment.

(4) The policy continues in full force and effect, subject to the requirements of subsection (3), until the proper 15-day notice has been given, unless the coverage has already been replaced.

(5) The 15-day period begins to run from the date of the proof of mailing.

(6) The issuer may collect premiums for any time period that the coverage remains in effect.

(7) When coverage is actually canceled, notice must also be mailed to all certificate holders at:

(a) their last-known home addresses if available; or

(b) the business address of the group policyholder.

(8) The notice of cancellation to certificate holders must be separate from the certificate of creditable coverage required in 33-22-142, although it may be mailed simultaneously with the certificate.

History: **En. Sec. 2, Ch. 384, L. 2003; amd. Sec. 28, Ch. 271, L. 2009.**

Part 6
Blanket Disability Insurance

33-22-601. Blanket disability insurance defined. Blanket disability insurance is hereby declared to be that form of disability insurance covering groups of persons as enumerated in one of the following subsections:

(1) under a policy or contract issued to any common carrier or to any operator, owner, or lessee of a means of transportation, who or which shall be deemed the policyholder, covering a group defined as all persons or all persons of a class who may become passengers on such common carrier or such means of transportation;

(2) under a policy or contract issued to an employer, who shall be deemed the policyholder, covering all employees, dependents, or guests, defined by reference to specified hazards incident to the activities or operations of the employer or any class of employees, dependents, or guests similarly defined;

(3) under a policy or contract issued to a school or other institution of learning, camp or sponsor thereof; or to the head or principal thereof, who or which shall be deemed the policyholder, covering students or campers. Supervisors and employees may be included.

(4) under a policy or contract issued in the name of any religious, charitable, recreational, educational, or civic organization, which shall be deemed the policyholder, covering participants in activities sponsored by the organization;

(5) under a policy or contract issued to a sports team or sponsors thereof, which shall be deemed the policyholder, covering members, officials, and supervisors;

(6) under a policy or contract issued in the name of any volunteer fire department, first aid, or other such volunteer group, or agency having jurisdiction thereof, which shall be deemed the policyholder, covering all of the members of such fire department or group;

(7) under a policy or contract issued to cover any other risk or class of risks which in the discretion of the commissioner may be properly eligible for blanket disability insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

History: En. Sec. 388, Ch. 286, L. 1959; R.C.M. 1947, 40-4104.

Cross-References

Volunteer fire departments, Title 7, ch. 33, part 23.

33-22-602. Required provisions of blanket policies. An insurer authorized to write disability insurance in this state has the power to issue blanket disability insurance. A blanket policy may not be issued or delivered in this state unless a copy of the policy form is filed in accordance with 33-1-501. A blanket policy must contain provisions that in the opinion of the commissioner are at least as favorable to the policyholder and the individual insured as the following provisions:

(1) the policy and the application constitute the entire contract between the parties, all statements made by the policyholder are, in absence of fraud, considered representations and not warranties, and statements may not be used in defense to a claim under the policy unless it is contained in a written application;

(2) written notice of sickness or of injury must be given to the insurer within 20 days after the date when the sickness or injury occurred. Failure to give notice within 20 days may not invalidate or reduce a claim if the insured shows that it was not reasonably possible to give the required notice and that notice was given as soon as was reasonably possible.

(3) the insurer will furnish to the policyholder forms for filing proof of loss. If forms are not furnished within 15 days after the insured provided notice of sickness or injury, the claimant is considered to have complied with the requirements of the policy as to proof of loss upon submitting, within the time established in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claim is made.

(4) in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within 30 days after the commencement of the period for which the insurer is liable and subsequent written proof of the continuance of the disability must be furnished to the insurer at intervals established by the insurer. In the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within 90 days after the

date of the loss. Failure to furnish proof within 90 days may not invalidate or reduce a claim if the insured shows it was not reasonably possible to furnish the required proof and that proof was furnished as soon as was reasonably possible.

(5) except as provided in 33-22-137, all benefits payable under the policy other than benefits for loss of time are payable immediately upon receipt of written proof of the loss. Subject to proof of loss, all accrued benefits payable under the policy for loss of time must be paid at least every 30 days during the period for which the insurer is liable. Any balance remaining unpaid at the termination of the period of liability must be paid immediately upon receipt of the proof of loss.

(6) the insurer at its own expense has the right and opportunity to examine the person of the insured when and as often as reasonably required during the pendency of a claim under the policy and also the right and opportunity to make an autopsy in case of death when it is not prohibited by law;

(7) an action at law or in equity may not be brought to recover a loss under the policy sooner than 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and no later than 3 years after the time written proof of loss is required to be furnished.

History: **En. Sec. 389, Ch. 286, L. 1959; R.C.M. 1947, 40-4105; amd. Sec. 29, Ch. 271, L. 2009.**

Cross-References

Standard application provision — warranties not representations, 33-15-403.
Requirement for redundant proofs of loss for delay — unfair trade practice, 33-18-201.
Failure to promptly pay — unfair trade practice, 33-18-201.
Limitations on performing autopsies, 50-21-103.

33-22-603. Application and certificates not required. An individual application shall not be required from a person covered under a blanket disability policy or contract, nor shall it be necessary for the insurer to furnish each person a certificate.

History: **En. Sec. 390, Ch. 286, L. 1959; R.C.M. 1947, 40-4106.**

33-22-604. Payment of claims — discharge. (1) (a) Subject to subsection (1)(b), all benefits under a blanket disability policy must be payable to:

(i) the person insured or to the person's designated beneficiary or beneficiaries or to the person's estate, except that if the person insured is a minor or is mentally incompetent, the benefits may be made payable to the parent, guardian, or other person actually supporting the person; or

(ii) the employer, if the entire cost of the insurance has been borne by the employer.

(b) The policy may provide that all or any portion of any indemnities provided by the policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services, but the policy may not require that the service be rendered by a particular hospital or person.

(2) Payment made as provided in subsection (1) discharges the insurer's obligation with respect to the amount of insurance paid.

History: **En. Sec. 391, Ch. 286, L. 1959; R.C.M. 1947, 40-4107; amd. Sec. 1230, Ch. 56, L. 2009.**

Part 7
Montana Mental Health Parity Act

Part Cross-References

Mentally ill, Title 53, ch. 21.
Alcoholism and drug dependence, Title 53, ch. 24.

33-22-701. Short title — purpose — scope of part — exceptions. (1) This part may be cited as the "Montana Mental Health Parity Act".

(2) The purpose of this part is to ensure that Montana law applies the same level of parity between mental health and physical health benefits as existed in federal law on January 1, 2017.

(3) The provisions of this part apply to all policies and certificates of individual and group health insurance and group health plans offered to, renewed for, or issued to Montana residents by any health insurance issuer.

(4) This part does not apply to a short-term travel policy, a blanket disability policy as defined in 33-22-601, or excepted benefits as defined in 33-22-140.

History: En. Sec. 1, Ch. 197, L. 1979; amd. Sec. 1, Ch. 535, L. 1981; amd. Sec. 1, Ch. 593, L. 1983; amd. Sec. 4, Ch. 384, L. 1987; amd. Sec. 2, Ch. 348, L. 1999; amd. Sec. 55, Ch. 227, L. 2001; amd. Sec. 2, Ch. 245, L. 2017.

Cross-References

Licensing of hospitals and related facilities, Title 50, ch. 5, part 2.
Facility standards, 53-24-208.

33-22-702. Definitions. For purposes of this part, the following definitions apply:

(1) "Inpatient benefits" are as set forth in 33-22-705.

(2) "Mental health benefits" means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice, including but not limited to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(3) "Mental health treatment center" means a treatment facility organized to provide care and treatment for mental illness or severe mental illness through multiple modalities or techniques pursuant to a written treatment plan approved and monitored by a qualified health care provider and a treatment facility that is:

(a) licensed as a mental health treatment center by the state;

(b) funded or eligible for funding under federal or state law; or

(c) affiliated with a hospital under a contractual agreement with an established system for patient referral.

(4) (a) "Mental illness" means a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with:

(i) present distress or a painful symptom;

(ii) a disability or impairment in one or more areas of functioning; or

(iii) a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

(b) Mental illness must be considered as a manifestation of a behavioral, psychological, or biological dysfunction in a person.

(c) Mental illness does not include:

(i) a developmental disorder;

(ii) a speech disorder;

(iii) a psychoactive substance use disorder;

(iv) an eating disorder, except for bulimia and anorexia nervosa; or

(v) an impulse control disorder, except for intermittent explosive disorder and trichotillomania.

(5) "Outpatient benefits" are as set forth in 33-22-705.

(6) "Primary care behavioral health model" means an evidence-based, integrated behavioral health care service delivery model delivered in primary or specialty care settings that recognizes licensed psychologists as consultants as well as direct service providers.

(7) "Psychiatric collaborative care model" means the evidence-based, integrated behavioral health service delivery method in which care:

(a) is delivered by a primary care team consisting of a primary care provider and a care manager who work in collaboration with a psychiatric consultant, including but not limited to a psychiatrist;

(b) is directed by the primary care team;

(c) includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate; and

(d) involves regular consultations between the psychiatric consultant and the primary care team to review the clinical status and care of patients and to make recommendations.

(8) "Qualified health care provider" means a person licensed as a physician, psychologist, social worker, clinical professional counselor, marriage and family therapist, or addiction counselor or another appropriate licensed health care practitioner.

(9) "Severe mental illness" means the following disorders as defined by the American psychiatric association:

(a) schizophrenia;
(b) schizoaffective disorder;
(c) bipolar disorder;
(d) major depression;
(e) panic disorder;
(f) obsessive-compulsive disorder; and
(g) autism.

(10) "Substance use disorder" means the uncontrollable or excessive use of an addictive substance, including but not limited to alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers, or hallucinogens, and the resultant physiological or psychological dependency that develops with continued use of the addictive substance and that requires medical care or other appropriate treatment as determined by a licensed addiction counselor or other appropriate medical practitioner.

(11) "Substance use disorder benefits" means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice, including but not limited to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(12) "Substance use disorder treatment center" means a treatment facility that:

(a) provides a program for the treatment of substance use disorders pursuant to a written treatment plan approved and monitored by a qualified health care provider; and

(b) is licensed or approved by the department of public health and human services under 53-24-208 or is licensed or approved by the state where the facility is located.

History: En. Sec. 2, Ch. 197, L. 1979; amd. Sec. 2, Ch. 535, L. 1981; amd. Sec. 2, Ch. 593, L. 1983; amd. Sec. 2, Ch. 302, L. 1985; amd. Sec. 2, Ch. 98, L. 1987; amd. Sec. 2, Ch. 606, L. 1987; amd. Sec. 1, Ch. 262, L. 1991; amd. Sec. 1, Ch. 448, L. 1995; amd. Sec. 83, Ch. 546, L. 1995; amd. Sec. 3, Ch. 348, L. 1999; amd. Sec. 1, Ch. 23, L. 2001; amd. Sec. 56, Ch. 227, L. 2001; amd. Sec. 3, Ch. 245, L. 2017; amd. Sec. 2, Ch. 277, L. 2021; amd. Sec. 2, Ch. 323, L. 2021.

Cross-References

Medicine — licensure, Title 37, ch. 3.
Licensure of psychologists, Title 37, ch. 17.
Board of Behavioral Health, Title 37, ch. 39.

33-22-703. Coverage for mental illness, severe mental illness, and substance use disorders — definition. (1) A health insurance issuer that issues, modifies, or renews individual or group health insurance coverage or a group health plan shall provide for the necessary care and treatment of mental illness, severe mental illness, and substance use disorders at a level of benefits that is no less favorable than the level provided for physical illness generally, including:

(a) inpatient benefits;
(b) outpatient benefits;
(c) emergency care; and
(d) prescription drugs.

(2) For the purposes of this section, "no less favorable" means the same level of parity as required under the Mental Health Parity and Addiction Equity Act of 2008 and related federal regulations as of January 1, 2017.

(3) Coverage for a child with autism who is 18 years of age or younger must comply with 33-22-515(3) through 33-22-515(5) if the child is diagnosed with:

(a) autistic disorder;
(b) Asperger's disorder; or
(c) pervasive developmental disorder not otherwise specified.

History: En. Sec. 3, Ch. 197, L. 1979; amd. Sec. 3, Ch. 535, L. 1981; amd. Sec. 3, Ch. 593, L. 1983; amd. Sec. 5, Ch. 139, L. 1987; amd. Sec. 5, Ch. 384, L. 1987; amd. Sec. 2, Ch. 448, L. 1995; amd. Sec. 150, Ch. 42, L. 1997; amd. Sec. 9, Ch. 416, L. 1997; amd. Sec. 1, Ch. 477, L. 1999; amd. Sec. 57, Ch. 227, L. 2001; amd. Sec. 15, Ch. 55, L. 2015; amd. Sec. 4, Ch. 245, L. 2017.

33-22-704. Repealed. Sec. 9, Ch. 245, L. 2017.

History: En. Sec. 4, Ch. 197, L. 1979; amd. Sec. 4, Ch. 535, L. 1981; amd. Sec. 4, Ch. 593, L. 1983; amd. Sec. 6, Ch. 384, L. 1987; amd. Sec. 4, Ch. 348, L. 1999; amd. Sec. 58, Ch. 227, L. 2001.

33-22-705. Inpatient and outpatient benefits — use of psychiatric collaborative care or primary care behavioral health model. (1) (a) Inpatient benefits are benefits payable for charges made by:

(i) a hospital or freestanding inpatient facility for the necessary care and treatment of mental illness, severe mental illness, or substance use disorder furnished to a covered person while confined as an inpatient; or

(ii) a qualified health care provider for the necessary care and treatment of mental illness, severe mental illness, or substance use disorder furnished to a covered person while confined as an inpatient.

(b) Care and treatment of a substance use disorder in a freestanding inpatient facility must be in a substance use disorder treatment center.

(c) Inpatient benefits include payment for medically monitored and medically managed intensive inpatient services and clinically managed high-intensity residential services.

(2) Outpatient benefits are benefits payable for:

(a) reasonable charges made by a hospital for the necessary care and treatment of mental illness, severe mental illness, or substance use disorder furnished to a covered person while not confined as an inpatient;

(b) reasonable charges for services rendered or prescribed by a qualified health care provider for the necessary care and treatment for mental illness, severe mental illness, or substance use disorder furnished to a covered person while not confined as an inpatient;

(c) reasonable charges made by a mental health or substance use disorder treatment center for the necessary care and treatment of a covered person provided in the treatment center while not confined as an inpatient;

(d) reasonable charges for services rendered by a qualified health care provider, hospital, mental health treatment center, or substance use disorder treatment center in an acute or subacute partial hospitalization or intensive outpatient treatment setting; or

(e) reasonable charges for outpatient benefits listed in this subsection (2) that are delivered through the psychiatric collaborative care model or primary care behavioral health model. The charges must be reimbursed through the use of the following common procedural terminology billing codes established by the American medical association:

(i) 99492;

(ii) 99493;

(iii) 99494;

(iv) 99484, the code for care management services for behavioral health conditions;

(v) 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, and 96171, the codes for health behavior assessment and intervention; and

(vi) 99446, 99447, 99448, 99449, and 99451, the codes for interprofessional telephone/internet/electronic health record consultations.

History: En. Sec. 1, Ch. 98, L. 1987; amd. Sec. 12, Ch. 606, L. 1987; amd. Sec. 1, Ch. 262, L. 1991; amd. Sec. 84, Ch. 546, L. 1995; amd. Sec. 11, Ch. 507, L. 1997; amd. Sec. 2, Ch. 477, L. 1999; amd. Sec. 2, Ch. 23, L. 2001; amd. Sec. 105, Ch. 483, L. 2001; amd. Sec. 5, Ch. 245, L. 2017; amd. Sec. 3, Ch. 277, L. 2021.

33-22-706. Repealed. Sec. 9, Ch. 245, L. 2017.

History: En. Sec. 1, Ch. 348, L. 1999; amd. Sec. 1, Ch. 367, L. 2001; amd. Sec. 5, Ch. 325, L. 2003; amd. Sec. 3, Ch. 359, L. 2009; amd. Sec. 22, Ch. 63, L. 2015.

33-22-707. Parity compliance records. A health insurance issuer that issues, modifies, or renews individual or group health insurance coverage that provides mental health or substance use disorder benefits shall submit a report to the commissioner on or before April 1 of the year following the effective date of this section, and upon request of the commissioner for each year thereafter, that complies with the mental health and substance use disorder parity analysis requirements of 42 U.S.C. 300gg-26(a)(8).

History: En. Sec. 1, Ch. 323, L. 2021.

33-22-708 and 33-22-709 reserved.

33-22-710. Rulemaking. The commissioner may adopt rules to implement the provisions of this part.

History: En. Sec. 6, Ch. 245, L. 2017.

Part 8
Extended Health Insurance
(Repealed)

33-22-801. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 1, Ch. 61, L. 1965; R.C.M. 1947, 40-5401.

33-22-802. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 2, Ch. 61, L. 1965; R.C.M. 1947, 40-5402.

33-22-803. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 3, Ch. 61, L. 1965; R.C.M. 1947, 40-5403(part).

33-22-804. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 5, Ch. 61, L. 1965; R.C.M. 1947, 40-5405; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 68, Ch. 596, L. 1993.

33-22-805. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 7, Ch. 61, L. 1965; R.C.M. 1947, 40-5407(part); amd. Sec. 1, Ch. 713, L. 1989.

33-22-806. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 8, Ch. 61, L. 1965; R.C.M. 1947, 40-5408.

33-22-807 through 33-22-810 reserved.

33-22-811. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 3, Ch. 61, L. 1965; R.C.M. 1947, 40-5403(part).

33-22-812. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 6, Ch. 61, L. 1965; R.C.M. 1947, 40-5406(part); amd. Sec. 24, Ch. 303, L. 1981.

33-22-813. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Secs. 3, 4, Ch. 61, L. 1965; R.C.M. 1947, 40-5403(part), 40-5404; amd. Sec. 13, Ch. 345, L. 1979; amd. Sec. 1, Ch. 713, L. 1989.

33-22-814. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 7, Ch. 61, L. 1965; R.C.M. 1947, 40-5407(part).

33-22-815. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 6, Ch. 61, L. 1965; R.C.M. 1947, 40-5406(part).

33-22-816. Repealed. Sec. 69, Ch. 472, L. 1999.

History: En. Sec. 6, Ch. 61, L. 1965; R.C.M. 1947, 40-5406(part).

Part 9
Medicare Supplement Insurance Minimum Standards

33-22-901. Short title. This part may be cited as the "Medicare Supplement Insurance Minimum Standards Act".

History: En. Sec. 1, Ch. 298, L. 1981.

33-22-902. Purpose. The purpose of this part is to establish minimum standards for medicare supplement policies and certificates and to establish a regulatory program that meets the requirements of 42 U.S.C. 1395ss(p)(1)(A).

History: En. Sec. 2, Ch. 298, L. 1981; amd. Sec. 1, Ch. 163, L. 1993.

33-22-903. Definitions. As used in this part, the following definitions apply:

(1) "Applicant" means:

(a) in the case of an individual medicare supplement policy, the person who seeks to contract for insurance benefits; and

(b) in the case of a group medicare supplement policy, the proposed certificate holder.

(2) "Certificate" means a certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

(5) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under 42 U.S.C. 1395ss(g)(1), or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare. The term does not include:

(a) a policy or contract of one or more employers or labor organizations or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers, organizations, and trustees, for employees or former employees, or a combination of current and former employees, or for members or former members, or a combination of current and former members, of the labor organizations; or

(b) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

History: En. Sec. 3, Ch. 298, L. 1981; amd. Sec. 2, Ch. 682, L. 1989; amd. Sec. 2, Ch. 163, L. 1993; amd. Sec. 31, Ch. 531, L. 1997.

33-22-904. Standards for policy provisions — rules. (1) A medicare supplement policy or certificate in force in this state may not contain benefits that duplicate benefits provided by medicare.

(2) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies and certificates. A requirement of this code relating to minimum required policy benefits, other than the minimum standards contained in this part, may not apply to medicare supplement policies and certificates. The standards are in addition to and in accordance with applicable laws of this state, including the provisions of Title 33, chapter 22, and may cover but are not limited to:

(a) terms of renewability;
(b) initial and subsequent conditions of eligibility;
(c) nonduplication of coverage;
(d) probationary periods;
(e) benefit limitations, exceptions, and reductions;
(f) elimination periods;
(g) requirements for replacement;
(h) recurrent conditions; and
(i) definitions of terms.

(3) The commissioner may adopt reasonable rules that prohibit policy or certificate provisions not otherwise specifically authorized by statute that, in the opinion of the

commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a medicare supplement policy or certificate.

(4) Notwithstanding any other provisions of the law, a medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(5) The commissioner may adopt rules necessary to conform medicare supplement policies and certificates to the requirements of federal law and federal regulations, including but not limited to rules:

(a) requiring refunds or credits if the policies or certificates do not meet loss requirements;

(b) establishing a uniform methodology for calculating and reporting loss ratios;

(c) ensuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(d) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; and

(e) establishing a policy for holding public hearings prior to approval of premium increases.

History: **En. Sec. 4, Ch. 298, L. 1981; amd. Sec. 3, Ch. 682, L. 1989; amd. Sec. 3, Ch. 163, L. 1993.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-22-905. Minimum standards for benefits and payment of claims — rules. The commissioner shall adopt reasonable rules to establish minimum standards for benefits, payment of claims, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates.

History: **En. Sec. 5, Ch. 298, L. 1981; amd. Sec. 4, Ch. 682, L. 1989; amd. Sec. 4, Ch. 163, L. 1993.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-22-906. Loss ratio standards and filing requirements — limits on compensation. (1) Medicare supplement policies and certificates must return to policyholders or certificate holders benefits that are reasonable in relation to the premium charged. The commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of medicare supplement policies and certificates on the basis of incurred claims experience or incurred health care expenses, where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices. Every issuer providing medicare supplement insurance benefits to a resident of this state shall make premium adjustments:

(a) necessary to produce an expected loss ratio under the policy or certificate that meets the minimum loss ratio standards for medicare supplement policies and certificates as established by rule; and

(b) expected to result in a loss ratio at least as great as that originally anticipated by the issuer when it established current premiums for the medicare supplement policy or certificate.

(2) The commissioner shall by rule establish the timing and manner of the premium adjustments. Every issuer providing medicare supplement policies or certificates in this state shall annually file with the commissioner its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this part. An issuer transacting medicare supplement insurance in this state may not adjust its rates more than twice a year and may not adjust its rates for the first year a policy is in force, except to allow for changes in federal laws or regulations relating to medicare. Each filing of rates and rating schedules must demonstrate that the actual and expected losses in relation to premiums complies with the requirements of this part.

(3) An issuer may not provide compensation to its insurance producers that is greater than the renewal compensation that would be paid on an existing policy or certificate if:

(a) the existing policy or certificate were replaced by another policy or certificate with the same issuer and the new benefits are substantially similar to the benefits under the old policy or certificate; and

(b) the old policy or certificate was issued by the same issuer or insurance group.

History: En. Sec. 6, Ch. 298, L. 1981; amd. Sec. 5, Ch. 682, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 5, Ch. 163, L. 1993; amd. Sec. 26, Ch. 151, L. 2017; amd. Sec. 25, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 25, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-907. Disclosure standards — informational brochure — rules. (1) In order to provide for full and fair disclosure in the sale of medicare supplement policies and certificates, a medicare supplement policy may not be delivered or issued for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the time that application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501. The filing must be made at least 60 days in advance of the date that the outline of coverage is delivered to any resident of this state.

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1).

(b) For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions.

(c) The outline of coverage must include:

(i) a description of the principal benefits and coverage provided in the policy or certificate;

(ii) a statement of the exceptions, reductions, and limitations contained in the policy or certificate;

(iii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time that the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(a) medicare supplement policies or certificates; or

(b) disability income policies.

(5) The commissioner may further adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies or certificates by persons eligible for medicare.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every issuer providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders and certificate holders, in a format that the commissioner prescribes by rule, of the changes that it has made to the medicare supplement policy or certificate.

History: En. Sec. 7, Ch. 298, L. 1981; amd. Sec. 6, Ch. 682, L. 1989; amd. Sec. 6, Ch. 163, L. 1993; amd. Sec. 32, Ch. 531, L. 1997; amd. Sec. 26, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 26, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-908. Notice of free examination. Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached to the policy or certificate stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. The issuer shall pay any refund made pursuant to this section directly to the applicant in a timely manner.

History: En. Sec. 8, Ch. 298, L. 1981; amd. Sec. 7, Ch. 682, L. 1989; amd. Sec. 7, Ch. 163, L. 1993.

33-22-909. Administrative procedures. Rules adopted pursuant to this part are subject to the provisions of 33-1-313 and Title 2, chapter 4.

History: En. Sec. 9, Ch. 298, L. 1981.

33-22-910. Filing requirements for advertising. Every issuer of medicare supplement policies or certificates in this state shall provide to the commissioner for the commissioner's approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium.

History: En. Sec. 8, Ch. 682, L. 1989; amd. Sec. 8, Ch. 163, L. 1993; amd. Sec. 33, Ch. 531, L. 1997.

33-22-911. Penalties. In addition to any other penalties for violations of the insurance code, the commissioner may after hearing require issuers violating any provision of or rule adopted under Title 33, chapter 16, or this part to cease marketing a medicare supplement policy or certificate in this state that is related directly or indirectly to the violation or take action that is necessary to comply with the provisions of Title 33, chapter 16, or this part or the rules adopted under Title 33, chapter 16, or this part, or both.

History: En. Sec. 9, Ch. 682, L. 1989; amd. Sec. 9, Ch. 163, L. 1993.

33-22-912 through 33-22-920 reserved.

33-22-921. Discontinuance or nonrenewal — alternate policy or certificate — same issuer. (1) If an issuer discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate to its insureds within this state, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured enrolls in and pays the premium for the replacing policy or certificate within 31 days after the termination of the replaced policy or certificate.

(2) An issuer who discontinues or does not renew a medicare supplement policy product or certificate and offers an alternate medicare supplement policy or certificate shall base its premium for the alternate policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

History: En. Sec. 1, Ch. 125, L. 1987; amd. Sec. 12, Ch. 798, L. 1991; amd. Sec. 27, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 27, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-922. Discontinuance or nonrenewal — alternate policy — unauthorized bulk reinsurance. (1) Alternate medicare supplement coverage as provided in 33-22-921 must be offered to its insureds by an issuer that:

(a) bulk cedes its medicare supplement policy business to an insurer that does not meet the requirements of chapter 2;

(b) authorizes the bulk reinsurer to administer the medicare supplement policies on its behalf; and

(c) discontinues or does not renew a medicare supplement policy product.

(2) The premium for the alternate policy referred to in subsection (1) must be based on actuarially justified rates.

History: En. Sec. 2, Ch. 125, L. 1987; amd. Sec. 28, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 28, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-923. Replacement policy or certificate — different issuer. (1) If an issuer replaces a medicare supplement policy or certificate, it may not deny benefits under the replacing policy or certificate to an insured who receives treatment for a condition that was a covered expense under the replaced policy or certificate and is a covered expense under the replacing policy or certificate if the insured pays the premium for the replacing policy or certificate when due or within 31 days after the termination of the replaced policy or certificate.

(2) An issuer who replaces a medicare supplement policy or certificate shall base its premium for the replacement policy or certificate on the rates currently in place for that policy or certificate.

(3) If the insured has not satisfied the preexisting condition limitation under the replaced medicare supplement policy or certificate, any period of time that was covered by that policy or certificate must be credited toward the preexisting condition limitation period of the replacing policy or certificate.

(4) To receive the benefits of subsections (1) through (3), a person shall submit to the replacing issuer proof of prior coverage, evidence of benefits provided under the previous policy or certificate, and the effective date and the date of termination of coverage under the previous policy or certificate.

History: En. Sec. 3, Ch. 125, L. 1987; amd. Sec. 13, Ch. 798, L. 1991; amd. Sec. 29, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 29, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-22-924. Renewal requirement. (1) If a person pays a renewal premium on the date it is due or within 31 days after it is due, an issuer may not refuse to renew a medicare supplement policy or certificate unless the issuer:

(a) refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class; and

(b) offers a replacement policy or certificate at actuarially justified rates.

(2) If an issuer refuses to renew all policies or certificates in this state that are of the same form and issued to persons of the same class, the policies or certificates will remain in force during the grace period stated in the replaced policy or certificate. An issuer's refusal to renew a policy or certificate may not affect a claim that arose under the discontinued policy or certificate during the period in which an insured was confined without interruption to a medical care facility for treatment.

History: En. Sec. 4, Ch. 125, L. 1987; amd. Sec. 14, Ch. 798, L. 1991; amd. Sec. 30, Ch. 8, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 30, Ch. 8, L. 2025. Amendment effective October 1, 2025.

Part 10
Home Health Care Coverage

33-22-1001. Definition of home health care. "Home health care" means services provided by a licensed home health agency to an insured in the insured's place of residence that is prescribed by the insured's attending physician as part of a written plan of care. Services provided by home health care include:

(1) nursing;
(2) home health aide services;
(3) physical therapy;
(4) occupational therapy;
(5) speech therapy;
(6) hospice service;
(7) medical supplies and equipment suitable for use in the home; and
(8) medically necessary personal hygiene, grooming, and dietary assistance.

History: En. Sec. 1, Ch. 508, L. 1981; amd. Sec. 1231, Ch. 56, L. 2009.

Cross-References

Hospitals and related facilities — general provisions, Title 50, ch. 5, part 1.

33-22-1002. Availability of coverage for home health care. Insurers and health service corporations transacting health insurance business in this state shall make available, under group insurance policies or certificates and under group hospital and medical service plan contracts, benefits for home health care. Applicants for a group policy, certificate, or contract may select any level of benefits that may be offered by the insurer or service plan corporation.

History: **En. Sec. 2, Ch. 508, L. 1981; amd. Sec. 59, Ch. 227, L. 2001.**

33-22-1003. Applicability. This part applies to policies, certificates, or contracts delivered or issued for delivery in this state after January 29, 1981, but does not apply to blanket, short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, to policies or contracts designed for coverage under Title XVIII of the Social Security Act, known as Medicare, or to any other similar coverage under federal governmental plans.

History: **En. Sec. 3, Ch. 508, L. 1981; amd. Sec. 60, Ch. 227, L. 2001.**

Part 11
Long-Term Care Insurance Act

33-22-1101. Short title. This part may be cited as the “Long-Term Care Insurance Act”.

History: **En. Sec. 1, Ch. 355, L. 1989.**

33-22-1102. Purpose. The purpose of this part is to:

(1) promote the public interest;

(2) promote the availability of long-term care insurance;

(3) protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices;

(4) establish standards for long-term care insurance;

(5) facilitate public understanding and comparison of long-term care insurance policies; and

(6) facilitate flexibility and innovation in the development of long-term care insurance coverage.

History: **En. Sec. 2, Ch. 355, L. 1989.**

33-22-1103. Compliance required. A policy may not be advertised, marketed, or offered in this state as long-term care insurance or nursing home insurance unless it complies with this part.

History: **En. Sec. 13, Ch. 355, L. 1989.**

33-22-1104. Scope. This part is not intended to supersede the obligations of entities subject to this part to comply with the substance of other applicable insurance laws insofar as they do not conflict with this part. However, laws and regulations designed and intended to apply to medicare supplement insurance policies may not be applied to long-term care insurance.

History: **En. Sec. 3, Ch. 32, L. 2007.**

33-22-1105 and 33-22-1106 reserved.

33-22-1107. Definitions. As used in this part, the following definitions apply:

(1) “Activities of daily living” means:

(a) eating;

(b) toileting;

(c) transferring;

(d) bathing;

(e) dressing; and

(f) continence.

(2) “Applicant” means:

(a) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(b) in the case of a group long-term care insurance policy, the proposed certificate holder.

(3) “Appropriate sale criteria” means the set of conditions that an insurance company is required to address with an applicant that help to determine whether or not a particular

insurance policy or contract offered for sale is appropriate to the applicant. These conditions must include but are not limited to any insurance premium involved in the policy, the income of the applicant, and the savings and investments of the applicant.

(4) "Certificate" means a certificate issued under a group long-term care insurance policy that has been delivered or issued for delivery in this state.

(5) "Group long-term care insurance" means a long-term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) (i) one or more employers;

(ii) a labor organization;

(iii) a trust established by an employer or labor organization; or

(iv) a trustee of a fund established by one or more employers or labor organizations or a combination of employers and labor organizations for:

(A) employees or former employees or a combination of employees and former employees; or

(B) members or former members of the labor organization or a combination of members and former members;

(b) any professional, trade, or occupational association for its current, former, or retired members or a combination of current, former, and retired members if the association:

(i) is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) has been maintained in good faith for purposes other than obtaining insurance; or

(c) an association, a trust, or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations.

(i) Prior to advertising, marketing, or offering the policy within this state, the association or the insurer of the association shall file evidence with the commissioner that the association has:

(A) a minimum of 100 persons at the outset;

(B) been organized and maintained in good faith for purposes other than obtaining insurance;

(C) been in active existence for at least 1 year; and

(D) a constitution and bylaws requiring that the association hold regular meetings at least annually to further purposes of the membership; except for credit unions, the association collects dues or solicits contributions from members; and the members have voting privileges and representation on the governing board and committees.

(ii) Thirty days after filing, the association must be considered to have satisfied the organizational requirements unless the commissioner finds that the association does not satisfy the organizational requirements.

(d) a group other than as described in subsections (5)(a) through (5)(c) if the commissioner determines that the:

(i) issuance of the group policy is not contrary to the best interests of the public;

(ii) issuance of the group policy would result in economies of acquisition or administration; and

(iii) benefits are reasonable in relation to the premiums charged.

(6) (a) "Long-term care insurance":

(i) means any insurance policy that is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person, on an expense-incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, or maintenance or personal-care services provided in a setting other than an acute care unit of a hospital;

(ii) may be issued by an insurer, fraternal benefit society, nonprofit health service corporation, prepaid health plan, health maintenance organization, or similar organization to the extent that the organization is otherwise authorized to issue life or health insurance;

(iii) includes group and individual annuities and life insurance policies that provide directly or that supplement long-term care insurance;

(iv) includes any product advertised, marketed, or offered as long-term care insurance regardless of any exceptions to the definition included in this section;

(v) includes a policy that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity; and

(vi) includes qualified long-term care insurance contracts.

(b) Long-term care insurance does not include:

(i) any insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage; or

(ii) life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(c) An insurance policy that is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage and that also contains long-term care insurance benefits of a duration of at least 6 months is not required to meet the requirements of this part unless the premium allocable to the long-term care insurance benefits contained in the policy is greater than 25% of the total policy premium.

(7) "Policy" means any policy, certificate, contract, membership contract, subscriber agreement, health care services agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, health service corporation, prepaid health plan, health maintenance organization, or similar organization.

(8) "Preexisting condition" means a condition for which medical advice or treatment was recommended by or received from a provider of health care services within 6 months preceding the effective date of coverage of an insured person.

(9) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirement of section 7702B of the Internal Revenue Code, 26 U.S.C. 7702B, if:

(i) the only insurance protection provided under the contract is coverage of qualified long-term care services, as defined in 33-22-1126. A contract may also satisfy the requirements of this subsection (9)(a) if payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(ii) the contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under 42 U.S.C. 1395 or would be reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subsection (9)(a) do not apply to expenses that are reimbursable under 42 U.S.C. 1395 only as a secondary payor. A contract may also satisfy the requirements of this subsection (9)(a) if payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(iii) the contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code, 26 U.S.C. 7702B(b)(1)(C);

(iv) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed. All refunds of premiums and all policyholder dividends or similar amounts under the contract are to be applied as a reduction in future premiums or to increase future benefits. However, a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract.

(v) the contract contains the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code, 26 U.S.C. 7702B(g); or

(b) a life insurance contract that provides long-term care coverage by rider or as a part of the contract as long as the contract complies with section 7702B(b) and (e) of the Internal Revenue Code, 26 U.S.C. 7702B(b) and (e).

(10) "Transferring" means moving into or out of a bed, chair, or wheelchair.

History: **En. Sec. 3, Ch. 355, L. 1989; amd. Sec. 2, Ch. 152, L. 1991; amd. Sec. 1, Ch. 240, L. 1995; amd. Sec. 10, Ch. 416, L. 1997; amd. Sec. 4, Ch. 32, L. 2007.**

Cross-References

Policy defined, 33-15-102.
Membership contract defined, 33-30-101.
Health care services agreement defined, 33-31-102.

33-22-1108. Preexisting condition — definition. (1) A long-term care insurance policy or certificate other than a policy or certificate issued to a group, as specified in 33-22-1107(5)(a)(ii), (5)(a)(iii), or (5)(a)(iv), may not use a definition of preexisting condition that is more restrictive than the definition in 33-22-1107.

(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) If a long-term care insurance policy or certificate replaces, with similar benefits, another long-term care insurance policy or certificate, the insurer issuing the replacing long-term care insurance policy or certificate shall waive any time periods applicable to preexisting conditions or probationary periods in the replacing long-term care insurance policy or certificate to the extent that similar time periods have been satisfied under the original policy.

(4) The commissioner may extend the limitation periods in subsections (1) and (2) as to specific age group categories in specific policy forms if extending the limitation periods is in the best interests of the public.

(5) An insurer may use an application form designed to elicit the complete health history of an applicant and on the basis of the answers on that application perform underwriting in accordance with the insurer's established underwriting standards. Unless otherwise provided in the long-term care insurance policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in subsection (2) expires. A long-term care insurance policy or certificate may not exclude or use a waiver or rider of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (2).

History: **En. Sec. 7, Ch. 355, L. 1989; amd. Sec. 151, Ch. 42, L. 1997; amd. Sec. 11, Ch. 416, L. 1997.**

33-22-1109 and 33-22-1110 reserved.

33-22-1111. Outline of coverage. (1) (a) An insurer shall deliver an outline of coverage as approved by the commissioner to a prospective applicant for long-term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(b) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of the outline of coverage.

(c) In the case of insurance producer solicitations, an insurance producer shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(d) In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the earlier of the applicant's request or the delivery of the policy.

(2) The outline of coverage must include:

(a) a description of the principal benefits and coverage provided in the policy;

(b) a statement of the principal exclusions, reductions, and limitations contained in the policy;

(c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premiums. Continuation or conversion provisions of a group policy must be specifically described.

(d) a statement that the outline of coverage is only a summary of the policy issued or applied for, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(e) a description of the terms under which the policy or certificate may be returned and the premium refunded;
(f) a brief description of the relationship of cost of care and benefits; and
(g) a statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract.
(3) The outline of coverage:
(a) must prominently display the name of the insurer;
(b) must be a freestanding document not dependent for purposes of reader comprehension upon any other document;
(c) must use no smaller than 12-point type; and
(d) may not contain material of an advertising nature.

History: **En. Sec. 11, Ch. 355, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 12, Ch. 416, L. 1997; amd. Sec. 5, Ch. 32, L. 2007.**

33-22-1112. Required content for certificate. A certificate issued pursuant to a group long-term care insurance policy that is delivered or issued for delivery in this state must include:
(1) a description of the principal benefits and coverage provided in the policy;
(2) a statement of the principal exclusions, reductions, and limitations contained in the policy; and
(3) a statement that the group master policy determines governing contractual provisions.

History: **En. Sec. 12, Ch. 355, L. 1989.**

33-22-1113. Disclosure and performance standards for long-term care insurance. (1) The commissioner may by rule adopt standards for full and fair disclosure, setting forth the manner, content, and disclosures required to be made in a long-term care insurance policy, including but not limited to:
(a) terms of renewability;
(b) initial and subsequent conditions of eligibility;
(c) nonduplication of coverage provisions;
(d) coverage of dependents;
(e) preexisting conditions;
(f) termination of insurance;
(g) continuation or conversion;
(h) probationary periods;
(i) limitations;
(j) exceptions;
(k) reductions;
(l) elimination periods;
(m) requirements for replacement;
(n) recurrent conditions;
(o) definition of terms;
(p) prohibitions on limitations and exclusions;
(q) extension of benefits;
(r) discontinuance and replacement of policies;
(s) unintentional lapse;
(t) prohibitions against postclaim underwriting;
(u) minimum standards for home health and community care benefits;
(v) inflation protection;
(w) incontestability period; and
(x) tax consequences.
(2) A group long-term care insurance policy must include a provision relating to conversion on termination of eligibility as described in 33-22-508 or include a provision for continuation of coverage that maintains coverage under the existing group policy if the coverage would otherwise terminate.

History: **En. Sec. 5, Ch. 355, L. 1989; amd. Sec. 13, Ch. 416, L. 1997.**

Cross-References

Conversion on termination of eligibility, 33-22-508.

33-22-1114. Prohibited practices and policy provisions. (1) An insurance company may not issue a refund to a person other than the owner of the policy or certificate.

(2) A long-term care insurance policy may not:

(a) be canceled, nonrenewed, or otherwise terminated on any grounds other than the insured's or certificate holder's failure to pay the premium;

(b) contain a provision establishing a new waiting period if existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(c) provide coverage for only skilled nursing care or provide substantially more coverage for skilled nursing care in a facility than coverage for lower levels of care.

History: En. Sec. 6, Ch. 355, L. 1989; amd. Sec. 2, Ch. 240, L. 1995; amd. Sec. 14, Ch. 416, L. 1997.

33-22-1115. Prior hospitalization or institutionalization. (1) A long-term care insurance policy may not be delivered or issued for delivery in Montana if the policy conditions eligibility for a benefit:

(a) on a prior hospitalization requirement;

(b) provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) other than waiver of premium, postconfinement benefits, postacute care benefits, or recuperative benefits, on a prior institutionalization requirement.

(2) A long-term care insurance policy containing a limitation or condition for eligibility other than those prohibited in subsection (1) must clearly label, in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits", the limitations or conditions, including any required number of days of confinement.

(3) A long-term care insurance policy that contains a benefit advertised, marketed, or offered as a home health care benefit may not condition receipt of a benefit on a prior institutionalization requirement.

(4) A long-term care insurance policy that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

(5) A long-term care insurance policy that provides benefits only following institutionalization may not condition the benefits upon admission to a facility for the same or a related condition within a period of less than 30 days after discharge from the institution.

History: En. Sec. 8, Ch. 355, L. 1989; amd. Sec. 15, Ch. 416, L. 1997; amd. Sec. 6, Ch. 32, L. 2007.

33-22-1116. Nonforfeiture benefits — offer requirement. (1) Except as provided in subsection (3), a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy that includes a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy.

(2) If a policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that must be available for a specified period of time following a substantial increase in premium rates.

(3) When a group long-term care insurance policy is issued, the offer required in subsection (1) must be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in 33-22-1107(5)(d), other than to a continuing care retirement community or other similar entity, the offer must be made to each proposed certificate holder.

History: En. Sec. 4, Ch. 240, L. 1995; amd. Sec. 7, Ch. 32, L. 2007.

33-22-1117. Appropriate sale criteria. (1) Appropriate sale criteria must be established and communicated to the consumer prior to the insurance company's acceptance of a person's application for long-term care insurance.

(2) This section may not preclude the purchase of a long-term care insurance policy by a consumer.

History: En. Sec. 5, Ch. 240, L. 1995.

33-22-1118 reserved.

33-22-1119. Right to return policy — free look — refunds upon denial of application. (1) A long-term care insurance applicant and insured has the right to return the policy within 30 days of the policy's delivery and to have the premium refunded if, after examination of the policy, the applicant or insured is not satisfied for any reason. A long-term care insurance policy must have a notice prominently printed on the first page of the policy or attached to the policy stating that the applicant or insured has the right to return the policy within 30 days of the policy's delivery and to have the premium refunded if, after examination of the policy, other than a certificate issued to a group defined in 33-22-1107(5)(a), the applicant or insured is not satisfied for any reason.

(2) An applicant or a person insured under a long-term care insurance policy issued pursuant to a direct response solicitation has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the applicant or the insured is not satisfied for any reason. A long-term care insurance policy issued pursuant to a direct response solicitation must have a notice prominently printed on the first page or attached to it stating that the applicant or the insured has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the applicant or the insured is not satisfied for any reason.

(3) If the application of a person for long-term care insurance is denied, any refund due the person must be refunded within 30 days of the denial or return of the application.

History: En. Sec. 10, Ch. 355, L. 1989; amd. Sec. 3, Ch. 240, L. 1995; amd. Sec. 8, Ch. 32, L. 2007.

33-22-1120. Extraterritorial jurisdiction. A group long-term care insurance policy or certificate may not be delivered or issued for delivery to a resident of Montana under a group policy issued in another state unless it is approved by:

(1) the commissioner; and

(2) the insurance regulatory official of a state that has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in Montana.

History: En. Sec. 4, Ch. 355, L. 1989; amd. Sec. 64, Ch. 379, L. 1995.

33-22-1121. Rules. The commissioner may adopt rules necessary to implement this part, including but not limited to rules that:

(1) establish loss ratio standards for long-term care insurance policies;

(2) promote premium adequacy and protect the policyholder in the event of substantial rate increases;

(3) establish minimum standards for insurance producer training, marketing practices, compensation, and testing;

(4) establish penalties and reporting practices for long-term care insurance;

(5) specify, with respect to nonforfeiture benefits and contingent benefits:

(a) the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies;

(b) the standards for nonforfeiture benefits;

(c) the rules regarding contingent benefits upon lapse, including:

(i) a determination of the specified period of time during which a contingent benefit upon lapse will be available;

(ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as described in 33-22-1116; and

(d) the types of appropriate sale criteria to be communicated at the time of application;

(6) establish a requirement for the mandatory triggering of policy benefits based upon the number of activities of daily living that an individual is capable or incapable of performing; and

(7) are necessary to implement a determination made by the secretary of health and human services pursuant to 45 CFR, parts 160 and 164, as to who is a licensed health care practitioner.

History: (1)En. Sec. 14, Ch. 355, L. 1989; (2)En. Sec. 9, Ch. 355, L. 1989; amd. Sec. 6, Ch. 240, L. 1995; amd. Sec. 16, Ch. 416, L. 1997; amd. Sec. 9, Ch. 32, L. 2007.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

General rulemaking authority of Commissioner, 33-1-313.

Benefit triggers, 33-22-1125.

33-22-1122. Policy waiting periods not cumulative. A waiting or elimination period contained in a long-term care insurance policy under which an insured is required to wait a specified period of time before receiving policy benefits must be concurrent with any 90-day period used to determine whether an individual is a chronically ill individual.

History: **En. Sec. 46, Ch. 416, L. 1997.**

33-22-1123. Delivery of policy — policy summary — monthly reports. (1) If an application for a long-term care insurance policy is approved, the issuer shall deliver the policy to the applicant or policyholder not later than 30 days after the date of approval.

(2) (a) At the time of delivery of an individual life insurance policy that provides long-term care benefits within the policy or by rider, a policy summary must be provided to the insured.

(b) In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, and whether or not a request is made, a policy summary must be delivered not later than at the time the policy is delivered.

(c) In addition to complying with any other applicable requirements, the summary must include:

(i) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(ii) an illustration of the amount of benefit, the length of benefit, and the guaranteed lifetime benefit, if any, for each covered person;

(iii) any exclusions, reductions, and limitations on benefits of long-term care;

(iv) a statement that any long-term care inflation protection option required by the Administrative Rules of Montana is or is not available under this policy;

(d) If applicable to the policy type, the summary must also include:

(i) a disclosure of the effects of other exercising rights under the policy;

(ii) a disclosure of guarantees related to long-term care costs of insurance charges; and

(iii) current and projected maximum lifetime benefits.

(3) The required provisions of the policy summary may be incorporated into a basic illustration required to be delivered in accordance with administrative rules or into the life insurance policy summary.

(4) Any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefits is in benefit payment status, a monthly report must be provided to the policyholder. The report must include:

(a) any long-term care benefits paid out during the month;

(b) an explanation of any changes in the policy, such as to death benefits or cash values, due to long-term care benefits being paid out; and

(c) the amount of long-term care benefits existing or remaining.

History: **En. Sec. 47, Ch. 416, L. 1997; amd. Sec. 10, Ch. 32, L. 2007.**

33-22-1124. Denial of claims. If a claim under a long-term care insurance policy is denied, the issuer shall, not later than 60 days after the date of a written request by the policyholder, certificate holder, or the representative of either of them:

(1) provide a written explanation of the reasons for the denial; and

(2) provide all information possessed by the issuer relating to the denial.

History: **En. Sec. 48, Ch. 416, L. 1997; amd. Sec. 11, Ch. 32, L. 2007.**

33-22-1125. Benefit triggers. (1) A long-term care insurance policy may not be delivered or issued for delivery in this state unless it complies with the requirements of this section and applicable rules for the triggering of mandatory provision of benefits.

(2) (a) A long-term care insurance policy must condition the payment of benefits on a determination of the insured's inability to perform activities of daily living or on cognitive impairment.

(b) Eligibility for the payment of benefits may not be more restrictive than requiring a deficiency in the ability to perform not more than three of the activities of daily living or requiring the presence of cognitive impairment.

(c) Insurers may use activities of daily living to trigger covered benefits that are in addition to those contained in the definition under 33-22-1107 or rules as long as they are defined in the policy.

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy. However, the provisions may not restrict or be in lieu of the requirements contained in subsections (1) and (2).

(4) For purposes of this section, the determination of a deficiency may not be more restrictive than:

(a) requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(b) if the deficiency is due to the presence of a cognitive impairment, the need for supervision or verbal cueing by another person in order to protect the insured or others.

(5) Assessments of activities of daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses, or social workers.

(6) Long-term care insurance policies must include a clear description of the process of appealing and resolving benefit determinations.

History: **En. Sec. 49, Ch. 416, L. 1997; amd. Sec. 12, Ch. 32, L. 2007.**

Cross-References

Adoption of rules for mandatory triggering of benefits, 33-22-1121.

33-22-1126. Additional standards for qualified long-term care contracts — definitions. (1) For the purposes of this section, the following definitions apply:

(a) (i) "Chronically ill individual" has the meaning provided by section 7702B(c)(2) of the Internal Revenue Code, 26 U.S.C. 7702B(c)(2), and means any individual who has been certified by a licensed health care practitioner as:

(A) being unable to perform without substantial assistance from another individual at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

(B) requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(ii) The term may not include an individual otherwise meeting the requirements of subsection (1)(a)(i)(A) or (1)(a)(i)(B) unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets the requirements of subsection (1)(a)(i)(A) or (1)(a)(i)(B).

(b) "Licensed health care practitioner" means a physician, as defined in section 1861(r)(1) of the Social Security Act, 42 U.S.C. 1395x(r)(1), a registered professional nurse, licensed social worker, or other individual who meets the requirements prescribed by the secretary of the treasury.

(c) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual, including the protection from threats to health and safety due to severe cognitive impairment.

(d) "Qualified long-term care services" means services that meet the requirements of section 7702(c)(1) of the Internal Revenue Code, 26 U.S.C. 7702(c)(1), and that:

(i) provide necessary diagnostic, preventative, therapeutic, curative, treatment, mitigation, and rehabilitative services;

(ii) provide maintenance or personal care services that are required by a chronically ill individual; and

(iii) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(2) A qualified long-term care insurance contract must condition the payment of benefits on a certification of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

(3) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (2) must be performed by the following licensed or certified professionals:

(a) physicians or registered professional nurses;

(b) licensed social workers; or

(c) other individuals who meet the requirements prescribed by the secretary of the treasury.

(4) Certifications required pursuant to subsection (2) may be performed by a licensed health care professional at the direction of the insurer as is reasonably necessary with respect

to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

(5) Qualified long-term care insurance contracts must include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

History: **En. Sec. 13, Ch. 32, L. 2007.**

33-22-1127. Incontestability period. (1) Upon a showing of misrepresentation that is material to the acceptance for coverage, a policy that has been in force for less than 6 months may be rescinded by the insurer or the insurer may deny an otherwise valid long-term care insurance claim.

(2) Upon a showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought, a policy that has been in force for at least 6 months but less than 2 years may be rescinded by the insurer or the insurer may deny an otherwise valid long-term care insurance claim.

(3) After a policy has been in force for 2 years, it is not contestable upon the grounds of misrepresentation alone. The policy may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(4) (a) A long-term care insurance policy may be field-issued if the compensation to the field issuer is not based on the number of policies sold.

(b) For purposes of subsection (4)(a), "field-issued" means a policy issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer and using the insurer's underwriting guidelines.

(5) If an insurer has paid benefits under the long-term care insurance policy, the benefit payments may not be recovered by the insurer if the policy is rescinded.

(6) In the event of the death of the insured, this section may not be applied to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In that situation, the remaining death benefits under the policy must be governed by Title 33, chapter 20. In all other situations, this section applies to life insurance policies that accelerate benefits for long-term care.

History: **En. Sec. 14, Ch. 32, L. 2007.**

33-22-1128. Insurance producer training requirements. (1) An individual may not sell, solicit, or negotiate long-term care insurance unless the individual is licensed as an insurance producer for disability or life insurance, has completed a one-time training course, and completes ongoing training within every 24-month period.

(2) The training requirements of this section may be approved as continuing education courses under Title 33, chapter 17, part 12.

(3) The one-time training course required by this section may not be less than 8 hours, and the ongoing training required by this section may not be less than 4 hours for each 24-month period.

(4) (a) The training must consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified state long-term care insurance partnership programs.

(b) The training must address but is not limited to:

(i) state and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including medicaid;

(ii) available long-term care services and providers;

(iii) changes or improvements in long-term care services or providers;

(iv) alternatives to the purchase of private long-term care insurance;

(v) the effect of inflation on benefits and the importance of inflation protection; and

(vi) consumer suitability standards and guidelines.

(5) The training required by this section may not include training that is specific to the insurer or a company product or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

(6) (a) An insurer subject to this section shall obtain verification that an insurance producer acting on the insurer's behalf receives the training required by this section before the insurance producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products.

(b) The insurer shall maintain records subject to this state's record retention requirements and make the verification of the insurance producer's compliance with training requirements available to the commissioner upon request.

(7) (a) An insurer subject to this section shall maintain records with respect to the training of its insurance producers concerning the distribution of its policies that will allow the commissioner to provide assurance to the department of public health and human services that insurance producers have received the required training and that the insurance producers have demonstrated an understanding of the insurer's policies and the relationship of the policies to public and private coverage of long-term care, including medicaid, in this state.

(b) The records must be maintained in accordance with this state's record retention requirements and must be made available to the commissioner upon request.

(8) The satisfaction of the training requirements required by this section in any state must be considered to satisfy the training requirements in this state.

History: En. Sec. 15, Ch. 32, L. 2007; amd. Sec. 27, Ch. 157, L. 2023.

33-22-1129. Penalties. In addition to any other penalty provided for in Title 33, an insurer or an insurance producer found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of long-term care insurance is subject to a fine of up to three times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

History: En. Sec. 16, Ch. 32, L. 2007.

Part 12

Limited Benefit Disability Insurance (Repealed)

33-22-1201. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 1, Ch. 606, L. 1991.

33-22-1202. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 2, Ch. 606, L. 1991; amd. Sec. 26, Ch. 504, L. 1995; amd. Sec. 85, Ch. 546, L. 1995.

33-22-1203. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 3, Ch. 606, L. 1991.

33-22-1204. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 4, Ch. 606, L. 1991.

33-22-1205. Repealed. Sec. 44, Ch. 531, L. 1997.

History: En. Sec. 5, Ch. 606, L. 1991.

Part 13

Montana Reinsurance Association Act

Part Compiler's Comments

Contingent Voidness: Section 18, Ch. 210, L. 2019, provided: "The implementation of [sections 1 through 15] [this part] is contingent upon the approval of the state innovation waiver under [section 15] [33-22-1322]. If the state innovation waiver is not approved, [this act] is void." On August 16, 2019, the U.S. department of health and human services and the U.S. department of the treasury, having completed a review of Montana's application, approved Montana's state innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act. This approval is effective for January 1, 2020, through December 31, 2024.

33-22-1301. Short title — purpose. This part may be cited as the "Montana Reinsurance Association Act". The purpose of this act is to establish a Montana-based public reinsurance program in order to stabilize the individual health insurance market, maintain competition, and reduce premiums.

History: En. Sec. 1, Ch. 210, L. 2019.

33-22-1302. Reinsurance association — mandatory membership — exceptions. (1) The Montana reinsurance association is established as a nonprofit legal entity. As a condition of doing business, an insurer that has issued or renewed disability insurance, as defined in 33-1-207, regardless of license type, in this state in the past 12 months must be a member of the association.

(2) Disability insurers are exempt from the requirement to be association members and are not subject to the assessment in 33-22-1313 if the insurers solely issue or administer one or more of the following coverage types under the Montana Insurance Code:

(a) self-funded multiple employer welfare arrangements licensed under chapter 35;

(b) disability insurance sold through a fraternal benefit society as described in chapter 7;

(c) excepted benefits as defined in 33-22-140;

(d) long-term care insurance as described in chapter 22, part 11; or

(e) disability income insurance as defined in 33-1-235.

History: **En. Sec. 2, Ch. 210, L. 2019.**

33-22-1303. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the Montana reinsurance association provided for in this part.

(2) "Attachment point" means the threshold amount for claims costs incurred by an eligible health insurer for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments.

(3) "Benefit year" means the calendar year for which an eligible health insurer provides coverage through an individual health insurance policy.

(4) "Board" means the association's board of directors provided for in 33-22-1306.

(5) "Coinsurance rate" means the rate at which the association will reimburse an eligible health insurer for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

(6) "Eligible health insurer" means a health insurer, health service corporation, or health maintenance organization that:

(a) offers individual health insurance coverage in the individual market, as defined in 33-22-140;

(b) offers a qualified health plan as defined in 42 U.S.C. 18021(a) that does not discriminate on the basis of health status in rating or issuance, covers all essential health benefits, and does not impose lifetime or annual limits or exclude preexisting conditions; and

(c) incurs claims costs for an individual enrollee's covered benefits in the applicable benefit year.

(7) "Major medical" health insurance includes individual market and employer group health insurance that:

(a) is guaranteed available;

(b) is guaranteed renewable;

(c) does not impose preexisting condition exclusions;

(d) (i) offers essential health benefits as defined in 42 U.S.C. 18022; or

(ii) for large employer group coverage, meets the federal requirements for minimum value;

(e) pays medical claims, with no lifetime or annual limits; and

(f) complies with the federal limits for maximum out-of-pocket.

(8) "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the Montana reinsurance program.

(9) "Program" means the Montana reinsurance program operated by the Montana reinsurance association.

(10) "Reinsurance cap" means the maximum amount of each claim incurred by an eligible health insurer for an enrolled individual's covered benefits in a benefit year, after which the claims costs for benefits are no longer eligible for reinsurance payments.

(11) "Reinsurance payments" means an amount paid by the association to an eligible health insurer under the program.

History: **En. Sec. 3, Ch. 210, L. 2019.**

33-22-1304 and 33-22-1305 reserved.

33-22-1306. Association board of directors. (1) The association is governed by a board of directors consisting of five directors who have experience in health care, health insurance, or finance as follows:

(a) three directors, one each from the eligible health insurers with the largest enrollment in the individual market. If there are fewer than three, the board shall select another director from a health insurance issuer that markets primarily major medical insurance.

(b) one insurer director appointed by the commissioner who is a participating member of the association; and

(c) one director appointed by the governor to represent the public interest.

(2) The board of directors may be reimbursed by the association for travel expenses but may not otherwise be compensated for their services.

(3) Each director has one vote.

(4) Initial appointments must be finalized no later than May 1, 2019, and the board shall meet for the first time no later than May 8, 2019.

History: En. Sec. 4, Ch. 210, L. 2019.

33-22-1307. Duties of commissioner — rulemaking. (1) The commissioner shall:

(a) oversee the activities of the association and the board;

(b) examine the affairs of the board and program;

(c) approve the plan of operation set by the board as needed within 30 days of receiving the plan or amendments to the plan from the board;

(d) with the assistance of the association, collect the assessment and the federal funding designated for this program;

(e) designate staff to attend meetings of the board and the association as an ex officio member; and

(f) require all eligible health insurers to calculate the premium amount the eligible health insurer would have charged for the benefit year if the Montana reinsurance program had not been established. The eligible health insurer shall submit this information as part of its rate filing. The commissioner shall consider this information as part of the rate review.

(2) The commissioner may adopt rules necessary to implement this part. Any proposed administrative rules must be submitted to the board for review and comment before the proposed rules are submitted to the secretary of state.

History: En. Sec. 5, Ch. 210, L. 2019.

33-22-1308. Board duties — powers. (1) The board shall:

(a) adopt a plan of operation and the reinsurance parameters for the following year, no later than June 15, 2019, in accordance with the requirements of this part, and update the plan of operation and reinsurance parameters, if needed, no later than May 1 of each succeeding year. The board shall submit its plan of operation to the commissioner for approval.

(b) establish administrative and accounting procedures for the association and the program;

(c) select an association administrator in accordance with 33-22-1309 who will pay reinsurance claims in accordance with the plan of operation; and

(d) set the budget for the reinsurance program for each policy year, including the assessment levels as provided in 33-22-1313 for the various members of the association.

(2) The board may:

(a) enter into contracts as necessary to carry out the purposes of this part;

(b) appoint appropriate actuarial or other committees as necessary to provide technical assistance and any other functions within the authority of the association; and

(c) apply for funds or grants from public or private sources.

(3) The board may be audited by the legislative auditor.

(4) An annual review of the association and the program for solvency and compliance must be performed by an independent certified public accountant using generally accepted accounting principles and submitted to the commissioner and the economic affairs committee of the legislature provided for in 5-5-223 as provided in 5-11-210 for review by June 30 of each year, beginning in 2020.

(5) The board shall prepare an annual report on operations and finance and send that report to the economic affairs interim committee as provided in 5-11-210 and the commissioner by June 30 of each year, beginning in 2020.

History: **En. Sec. 6, Ch. 210, L. 2019.**

33-22-1309. Association administrator. (1) The board shall select an administrator, who is either an employee of the nonprofit association or an independent contractor, to administer the reinsurance program pursuant to the parameters decided by the board of directors. The board shall establish qualifications and compensation in the plan of operation for the administrator and the length of the contract of an independent contractor.

(2) The administrator shall:

(a) perform all administrative functions relating to the association;

(b) submit regular reports to the board regarding the operation of the association. The frequency, content, and form of the reports must be set forth in the plan of operation.

(c) pay reinsurance claims as provided for in the plan of operation.

History: **En. Sec. 7, Ch. 210, L. 2019.**

33-22-1310 through 33-22-1312 reserved.

33-22-1313. Association member assessments. (1) (a) (i) For 2020 and each year thereafter, the commissioner shall assess each member insurer 1.2% of its total premium volume covering Montana residents, from the prior calendar year, regardless of type of license.

(ii) For purposes of subsection (1)(a)(i), total premium volume may not include premiums that member insurers collect on any coverage issued for excepted benefits as defined in 33-22-140.

(b) The board shall determine the timing of the assessment.

(c) The commissioner shall consider the board's recommendation when determining the assessment amounts.

(d) The commissioner shall verify the amount of each insurer's assessment based on annual financial statements and other reports determined to be necessary.

(2) The association shall determine and report to the commissioner the association's reinsurance payments and other expenses for the previous calendar year, including administrative expenses and any incurred but not reported claims for the previous calendar year.

(a) The report must consider investment income and other appropriate gains.

(b) The report must include an estimate of the assessments needed to cover the expected reinsurance claims for the following calendar year.

(3) If assessments and other funds collected by the association exceed the actual losses and administrative expenses of the association, the board shall use the excess funds to offset future claims or to reduce future assessments.

(4) The commissioner may, after notice and hearing:

(a) suspend or revoke the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment;

(b) impose a penalty on any insurer that fails to pay an assessment when due; or

(c) use any power granted to the commissioner to collect any unpaid assessment.

(5) An eligible health insurer may not submit claims for reinsurance payments unless the insurer has a medical loss ratio of 80% or greater, as defined in 45 CFR 158.232(f).

History: **En. Sec. 8, Ch. 210, L. 2019; amd. Sec. 6, Ch. 471, L. 2021.**

33-22-1314. Payment parameters. (1) The board shall design and adjust the payment parameters to ensure that the payment parameters will:

(a) stabilize or reduce premium rates in the individual market;

(b) increase or maintain participation in the individual market;

(c) mitigate the impact high-cost individuals have on premium rates in the individual market;

(d) consider any federal funding available for the plan; and

(e) consider the total amount available to fund the plan.

(2) The attachment point must be set by the board at $40,000 or more but may not exceed the reinsurance cap.

(3) The coinsurance rate must be set by the board between 50% and 80%.

(4) The reinsurance cap must be set by the board at $1 million or less.

(5) The board may adjust the payment parameters annually to the extent necessary to secure federal approval of the state innovation waiver.

History: **En. Sec. 9, Ch. 210, L. 2019.**

33-22-1315. Calculation of reinsurance payments. (1) Each reinsurance payment must be calculated with respect to an eligible health insurer's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment point, the reinsurance payment must be calculated as the product of the coinsurance rate and the less of:

(a) the claims costs minus the attachment point; or

(b) the reinsurance cap minus the attachment point.

(2) The board shall ensure that the reinsurance payments made to the eligible health insurer do not exceed the total amount paid by the eligible health insurer for any eligible claim.

(3) For purposes of this section, "total amount paid" means the amount paid by the eligible health insurer based on the allowed amount less any deductible, coinsurance, or copayment.

History: **En. Sec. 10, Ch. 210, L. 2019.**

33-22-1316. Administration of reinsurance payments. (1) Claims that are incurred during a benefit year and are submitted for reimbursement in the following benefit year by the date established by the board in the plan of operation will be allocated to the benefit year in which they are incurred. Any claims from the preceding benefit year not submitted for reimbursement by the date established in the plan of operation may not be reimbursed.

(2) If funds accumulated in the reinsurance program account in the state special revenue fund with respect to a benefit year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that benefit year, all claims for reimbursement allocable to that benefit year must be reduced proportionately to the extent necessary to prevent a deficiency in the funds for that benefit year. Any reduction in claims for reimbursement with respect to a benefit year must apply to all claims that are allocated to that benefit year without regard to when those claims were submitted for reimbursement, and any reduction must be applied to each claim in the same proportion.

(3) If funds accumulated in the reinsurance program account in the state special revenue fund exceed the actual claims for reimbursement and program expenses of the association in a given benefit year, the board shall use the excess funds to pay reinsurance claims in successive benefit years and may recommend to the commissioner a reduction in the assessment amount for the following year.

(4) For each applicable benefit year, the board shall notify eligible health insurers of reinsurance payments to be made for the applicable benefit year by the date established in the plan of operation in the year following the applicable benefit year.

(5) By December 31 of the year following the applicable benefit year, the board shall disburse all applicable reinsurance payments payable to an eligible health insurer.

History: **En. Sec. 11, Ch. 210, L. 2019; amd. Sec. 7, Ch. 471, L. 2021; amd. Sec. 28, Ch. 157, L. 2023.**

33-22-1317. Eligible health insurer requests for reinsurance payments. (1) An eligible health insurer shall:

(a) make requests for reinsurance payment in accordance with any requirements established by the board;

(b) provide the association with access to data according to the rules and timeline established by the board in the plan of operation or by the commissioner in the administrative rules. The data environment utilized must be compatible with the federal risk adjustment program.

(c) maintain documents and records sufficient to substantiate the requests for reinsurance payments made pursuant to this part for a period of at least 6 years;

(d) apply all managed care, utilization review, case management, preferred provider arrangements, claims processing, and other methods of operation as appropriate to each claim without regard to whether that claim is eligible for or may be paid by reinsurance;

(e) make records available upon request from the commissioner or the board for purposes of verification, investigation, audit, or other review of reinsurance payment requests; and

(f) repay to the reinsurance program account in the state special revenue fund any reinsurance overpayments as determined by the commissioner as a result of an investigation, audit, or other review.

(2) Data collected from eligible health insurers under this section is confidential and not subject to public inspection.

History: En. Sec. 12, Ch. 210, L. 2019.

33-22-1318 and 33-22-1319 reserved.

33-22-1320. Liability of association members. An association member may not be held liable for the acts or omissions of the association board or the association membership.

History: En. Sec. 13, Ch. 210, L. 2019.

33-22-1321. *(Temporary)* **State and federal special revenue accounts — reinsurance program.** (1) (a) There is a reinsurance program account in the state special revenue fund established by 17-2-102. The account must be administered by the commissioner for the benefit of the program. The money in the reinsurance program account is statutorily appropriated, as provided in 17-7-502, to the commissioner for the purposes provided in subsection (1)(c) of this section.

(b) There must be deposited in the account:

(i) all assessments collected under 33-22-1313;

(ii) any interest and income earned on the account; and

(iii) any other money from any other source accepted for the benefit of the account.

(c) The account may be used only to provide funding for the administration, operation, and claims expenses incurred by the program created in 33-22-1302.

(2) There is an account in the federal special revenue fund to the credit of the board and administered by the commissioner for the benefit of the program. There must be deposited in the account:

(a) federal funding allocated as a result of a section 1332 waiver application;

(b) any federal or grant funding; and

(c) any interest and income earned on the account. *(Terminates June 30, 2031—sec. 5, Ch. 645, L. 2025.)*

33-22-1321. *(Effective July 1, 2031)* **State and federal special revenue accounts — reinsurance program.** (1) (a) There is a reinsurance program account in the state special revenue fund established by 17-2-102. The account must be administered by the commissioner for the benefit of the program.

(b) There must be deposited in the account:

(i) all assessments collected under 33-22-1313;

(ii) any interest and income earned on the account; and

(iii) any other money from any other source accepted for the benefit of the account.

(c) The account may be used only to provide funding for the administration, operation, and claims expenses incurred by the program created in 33-22-1302.

(2) There is an account in the federal special revenue fund to the credit of the board and administered by the commissioner for the benefit of the program. There must be deposited in the account:

(a) federal funding allocated as a result of a section 1332 waiver application;

(b) any federal or grant funding; and

(c) any interest and income earned on the account.

History: En. Sec. 14, Ch. 210, L. 2019; amd. Sec. 2, Ch. 645, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 2, Ch. 645, L. 2025. Amendment effective May 12, 2025, and terminates June 30, 2031.

33-22-1322. State innovation waiver. The commissioner, the governor, and the board shall jointly apply, no later than July 1, 2019, to the U.S. secretary of health and human services under 42 U.S.C. 18052 for a state innovation waiver and federal pass-through funding to implement this part for benefit years beginning January 1, 2020, and future years to maximize federal funding.

History: En. Sec. 15, Ch. 210, L. 2019.

Part 14 reserved

Part 15
Comprehensive Health Association and Plan
(Repealed)

33-22-1501. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 1, Ch. 595, L. 1985; amd. Sec. 15, Ch. 798, L. 1991; amd. Sec. 5, Ch. 357, L. 1995; amd. Sec. 17, Ch. 416, L. 1997; amd. Sec. 1, Ch. 173, L. 1999; amd. Sec. 1, Ch. 453, L. 2003; amd. Sec. 29, Ch. 469, L. 2005; amd. Sec. 1, Ch. 133, L. 2011; amd. Sec. 1, Ch. 404, L. 2013; amd. Sec. 23, Ch. 63, L. 2015.

33-22-1502. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 2, Ch. 595, L. 1985; amd. Sec. 2, Ch. 367, L. 2001; amd. Sec. 2, Ch. 453, L. 2003; amd. Sec. 30, Ch. 469, L. 2005; amd. Sec. 2, Ch. 404, L. 2013; amd. Sec. 24, Ch. 63, L. 2015.

33-22-1503. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 3, Ch. 595, L. 1985; amd. Sec. 6, Ch. 357, L. 1995; amd. Sec. 2, Ch. 173, L. 1999; amd. Sec. 2, Ch. 528, L. 1999.

33-22-1504. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 4, Ch. 595, L. 1985; amd. Sec. 16, Ch. 798, L. 1991; amd. Sec. 7, Ch. 357, L. 1995; amd. Sec. 3, Ch. 173, L. 1999; amd. Sec. 3, Ch. 528, L. 1999; amd. Sec. 2, Ch. 133, L. 2011; amd. Sec. 3, Ch. 404, L. 2013; amd. Sec. 25, Ch. 63, L. 2015.

33-22-1505. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 13, Ch. 595, L. 1985.

33-22-1506 through 33-22-1510 reserved.

33-22-1511. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 5, Ch. 595, L. 1985; amd. Sec. 26, Ch. 798, L. 1991.

33-22-1512. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 8, Ch. 595, L. 1985; amd. Sec. 27, Ch. 798, L. 1991; amd. Sec. 8, Ch. 357, L. 1995; amd. Sec. 18, Ch. 416, L. 1997; amd. Sec. 1, Ch. 475, L. 2001; amd. Sec. 41, Ch. 380, L. 2003; amd. Sec. 3, Ch. 133, L. 2011.

33-22-1513. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 9, Ch. 595, L. 1985; amd. Sec. 31, Ch. 112, L. 1991; amd. Sec. 17, Ch. 798, L. 1991; amd. Sec. 29, Ch. 349, L. 1993; amd. Sec. 19, Ch. 416, L. 1997; amd. Sec. 4, Ch. 528, L. 1999; amd. Sec. 3, Ch. 367, L. 2001; amd. Sec. 2, Ch. 475, L. 2001; amd. Sec. 42, Ch. 380, L. 2003; amd. Sec. 3, Ch. 453, L. 2003; amd. Sec. 31, Ch. 469, L. 2005; amd. Sec. 26, Ch. 63, L. 2015.

33-22-1514. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 10, Ch. 595, L. 1985; amd. Sec. 28, Ch. 798, L. 1991; amd. Sec. 5, Ch. 528, L. 1999; amd. Sec. 32, Ch. 469, L. 2005; amd. Sec. 11, Ch. 120, L. 2013.

33-22-1515. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 11, Ch. 595, L. 1985; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 29, Ch. 798, L. 1991; amd. Sec. 9, Ch. 357, L. 1995; amd. Sec. 5, Ch. 173, L. 1999; amd. Sec. 33, Ch. 469, L. 2005.

33-22-1516. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 12, Ch. 595, L. 1985; amd. Sec. 30, Ch. 798, L. 1991; amd. Sec. 10, Ch. 357, L. 1995; amd. Sec. 20, Ch. 416, L. 1997; amd. Sec. 6, Ch. 173, L. 1999; amd. Sec. 4, Ch. 453, L. 2003; amd. Sec. 34, Ch. 469, L. 2005.

33-22-1517. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 1, Ch. 357, L. 1995; amd. Sec. 35, Ch. 469, L. 2005; amd. Sec. 16, Ch. 399, L. 2007.

33-22-1518. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 2, Ch. 357, L. 1995.

33-22-1519 and 33-22-1520 reserved.

33-22-1521. Repealed. Sec. 35, Ch. 63, L. 2015.

History: En. Sec. 6, Ch. 595, L. 1985; amd. Sec. 31, Ch. 798, L. 1991; amd. Sec. 11, Ch. 357, L. 1995; amd. Sec. 152, Ch. 42, L. 1997; amd. Sec. 7, Ch. 173, L. 1999; amd. Sec. 4, Ch. 367, L. 2001; amd. Sec. 4, Ch. 133, L. 2011.

33-22-1522. Repealed. Sec. 34, Ch. 798, L. 1991.

History: En. Sec. 7, Ch. 595, L. 1985.

33-22-1523. Repealed. Sec. 35, Ch. 63, L. 2015.
History: **En. Sec. 41, Ch. 416, L. 1997.**

33-22-1524. Repealed. Sec. 35, Ch. 63, L. 2015.
History: **En. Sec. 1, Ch. 528, L. 1999; amd. Sec. 5, Ch. 453, L. 2003.**

Part 16
Subrogation — Notice

Part Cross-References
State employee group insurance — subrogation — notice, Title 2, ch. 18, part 9.
Health service corporations — subrogation — notice, Title 33, ch. 30, part 11.

33-22-1601. Subrogation rights. A disability insurance policy subject to this chapter may contain a provision providing that, to the extent necessary for reimbursement of benefits paid to or on behalf of the insured, the insurer is entitled to subrogation, as provided for in 33-22-1602, against a judgment or recovery received by the insured from a third party found liable for a wrongful act or omission that caused the injury necessitating benefit payments.
History: **En. Sec. 1, Ch. 365, L. 1987.**

33-22-1602. Notice — shared costs of third-party action — limitation. (1) If an insured intends to institute an action for damages against a third party, the insured shall give the insurer reasonable notice of the intention to institute the action.

(2) The insured may request that the insurer pay a proportionate share of the reasonable costs of the third-party action, including attorney fees.

(3) An insurer may elect not to participate in the cost of the action. If an election is made, the insurer waives 50% of any subrogation rights granted to it by 33-22-1601.

(4) The insurer's right of subrogation granted in 33-22-1601 may not be enforced until the injured insured has been fully compensated for the insured's injuries.
History: **En. Sec. 3, Ch. 365, L. 1987; amd. Sec. 1232, Ch. 56, L. 2009.**

Part 17
Preferred Provider Agreements

33-22-1701. Short title. This part may be cited as the "Preferred Provider Agreements Act".
History: **En. Sec. 1, Ch. 638, L. 1987.**

33-22-1702. Purpose. The purpose of this part is to allow a health care insurer providing disability insurance benefits to negotiate and contract with health care providers to:

(1) provide health care services to its insureds or subscribers at a reduction in the fees customarily charged by the provider; or

(2) enter into agreements in which the participating providers accept negotiated fees as payment in full for health care services the health care insurer is obligated to provide or pay for under the health benefit plan.
History: **En. Sec. 2, Ch. 638, L. 1987.**

33-22-1703. Definitions. As used in this part, the following definitions apply:

(1) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(2) "Emergency services" means health care items or services furnished or required to evaluate and treat an emergency medical condition.

(3) "Health benefit plan" means the health insurance policy or subscriber arrangement between the insured or subscriber and the health care insurer that defines the covered services and benefit levels available.

(4) "Health care insurer" means:

(a) an insurer that provides disability insurance as defined in 33-1-207;

(b) a health service corporation as defined in 33-30-101;
(c) a fraternal benefit society as described in 33-7-105; or
(d) any other entity regulated by the commissioner that provides health coverage except a health maintenance organization.

(5) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization or services provided under Title 33, chapter 22, part 7.

(6) "Insured" means an individual entitled to reimbursement for expenses of health care services under a policy or subscriber contract issued or administered by an insurer.

(7) "Preferred provider" means a provider or group of providers who have contracted to provide specified health care services.

(8) "Preferred provider agreement" means a contract between or on behalf of a health care insurer and a preferred provider.

(9) "Provider" means an individual or entity licensed or legally authorized to provide health care services or services covered within Title 33, chapter 22, part 7.

(10) "Subscriber" means a certificate holder or other person on whose behalf the health care insurer is providing or paying for health care coverage.

History: En. Sec. 3, Ch. 638, L. 1987; amd. Sec. 67, Ch. 713, L. 1989; amd. Sec. 40, Ch. 586, L. 1991; amd. Sec. 32, Ch. 451, L. 1993; amd. Sec. 1, Ch. 413, L. 1997.

33-22-1704. Preferred provider agreements authorized. (1) Notwithstanding any other provision of law to the contrary, a health care insurer may:

(a) enter into agreements with providers relating to health care services that may be rendered to insureds or subscribers on whose behalf the health care insurer is providing health care coverage, including preferred provider agreements relating to:
(i) the amounts an insured may be charged for services rendered; and
(ii) the amount and manner of payment to the provider; and
(b) issue or administer policies or subscriber contracts in this state that include incentives for the insured to use the services of a provider that has entered into an agreement with the insurer pursuant to subsection (1)(a).

(2) A preferred provider agreement issued or delivered in this state may not unfairly deny health benefits for health care services covered.

(3) A preferred provider agreement entered into or renewed after March 26, 1993, must provide each health care provider with the opportunity to participate on the basis of a competitive bid or offer. For each health care service that an insurer proposes to obtain for its insureds from a preferred provider in the geographic area covered by the proposal, the insurer shall provide all known providers of the health care service in that area with an equal opportunity to submit a competitive bid or offer to become a preferred provider. Except as provided in subsection (5), the insurer shall issue a request for proposals and shall select the lowest cost bid or offer. If only one bid or offer is received, the insurer may enter into a preferred provider agreement with the health care provider.

(4) If a bid or an offer is not received in response to a request for proposals under subsection (3), the insurer may not establish a preferred provider agreement for that service in the geographic area except pursuant to a new request for proposals.

(5) An insurer may reserve the right in its request for proposals to reject bids or offers submitted in response to the request, including the lowest cost bid or offer. A bid or offer must be rejected in the manner established in the request for proposals. An insurer may not enter into a preferred provider agreement for a health care service except pursuant to a request for proposals.

History: En. Sec. 4, Ch. 638, L. 1987; amd. Sec. 1, Ch. 714, L. 1991; amd. Sec. 1, Ch. 202, L. 1993.

33-22-1705. Incentives in health benefit plans. (1) A health care insurer may issue a policy or a health benefit plan that provides for incentives for covered persons to use the health care services of preferred providers. The policy or health benefit plan must contain at least:

(a) a provision that if a covered person receives emergency care for services specified in the preferred provider agreement and cannot reasonably reach a preferred provider, the care rendered during the course of the emergency will be reimbursed as though the covered person had been treated by a preferred provider; and

(b) a provision that clearly identifies the difference in benefit levels for health care services of a preferred provider and benefit levels for the same health care services of a nonpreferred provider.

(2) A health care insurer may not require hospital staff privileges as criteria for designation as a preferred provider in a preferred provider agreement.

History: **En. Sec. 5, Ch. 638, L. 1987.**

33-22-1706. Permissible and mandatory provisions in provider agreements, insurance policies, and subscriber contracts. (1) A provider agreement, insurance policy, or subscriber contract issued or delivered in this state may contain components designed to control the cost and improve the quality of health care for insureds and subscribers as provided in this part.

(2) All terms or conditions of an insurance policy or subscriber contract, except those already approved by the commissioner, are subject to the prior approval of the commissioner.

(3) Provisions designed to control cost and improve the quality of health care under this section include but are not limited to those that set a payment difference for reimbursement of a nonpreferred provider as compared to a preferred provider and those designed to give policyholders or subscribers an incentive to choose a particular provider consistent with the other provisions of this part.

(4) (a) A health benefit plan that contains a payment difference provision and that the commissioner has determined to have an adequate provider network is not subject to subsection (4)(b).

(b) A health benefit plan that contains a payment difference provision and has not been determined to have an adequate provider network may not exceed a 25% payment difference in the reimbursement level for a preferred provider, and the commissioner shall review differences between copayments, deductibles, and other cost-sharing arrangements under this subsection (4)(b).

(c) For the purposes of this subsection (4), a provider network is adequate if:

(i) the network includes at least 80% of the licensed individual physicians actively practicing in the state of Montana;

(ii) the network includes at least 80% of the licensed individual nonphysician health care providers actively practicing in the state of Montana; and

(iii) the network includes at least 90% of those facilities licensed and operating as hospitals in the state of Montana.

(5) A health benefit plan or other plan offering prepaid dental services under this part shall offer its insureds the right to obtain dental care from any licensed dental care provider of their choice subject to the same terms and conditions imposed under this section.

History: **En. Sec. 6, Ch. 638, L. 1987; amd. Sec. 1, Ch. 265, L. 1989; amd. Sec. 1, Ch. 306, L. 2013.**

Cross-References

Disability insurance — freedom of choice in selection of practitioners, 33-22-111.

Dentist participation as provider through health maintenance organization, 33-31-305.

33-22-1707. Rules. The commissioner may adopt rules necessary to implement the provisions of this part.

History: **En. Sec. 7, Ch. 638, L. 1987; amd. Sec. 2, Ch. 413, L. 1997.**

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

Part 18
Small Employer Health Insurance Availability Act

33-22-1801. Short title. This part may be cited as the "Small Employer Health Insurance Availability Act".

History: **En. Sec. 22, Ch. 606, L. 1993.**

33-22-1802. Purpose. (1) This part must be interpreted and construed to effectuate the following express legislative purposes:

(a) to promote the availability of health insurance coverage to small employers regardless of health status or claims experience;

(b) to prevent abusive rating practices;

(c) to require disclosure of rating practices to purchasers;

(d) to establish rules regarding renewability of coverage;

(e) to establish limitations on the use of preexisting condition exclusions;

(f) to provide for the development of basic and standard health benefit plans to be offered to all small employers;

(g) to provide for the establishment of a reinsurance program; and

(h) to improve the overall fairness and efficiency of the small employer health insurance market.

(2) This part is not intended to provide a comprehensive solution to the problem of affordability of health care or health insurance.

History: **En. Sec. 23, Ch. 606, L. 1993.**

33-22-1803. Definitions. As used in this part, the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Assessable carrier" means all carriers of disability insurance, including excess of loss and stop loss disability insurance.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan.

(6) "Benefit value" means a numerical value based on the expected dollar value of benefits payable to an insured under a health benefit plan. The benefit value must be calculated by the small employer carrier using an actuarially based method and must take into account all health care expenses covered by the health benefit plan and all cost-sharing features of the health benefit plan, including deductibles, coinsurance, copayments, and the insured individual's maximum out-of-pocket expenses. The benefit value must apply equally to indemnity-type health benefit plans and to managed care health benefit plans, including health maintenance organization-type plans.

(7) "Bona fide association" means an association that:

(a) has been actively in existence for at least 5 years;

(b) was formed and has been maintained in good faith for purposes other than obtaining insurance;

(c) does not condition membership in the association on a health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(d) makes health insurance coverage offered through the association available to a member regardless of a health status-related factor relating to the member or an individual eligible for coverage through a member; and

(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(8) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, and a health maintenance organization. For purposes of this part, companies that are affiliated companies or that are eligible to file

a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(9) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that gender, claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

(10) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

(11) "Dependent" means:

(a) a spouse;

(b) an unmarried child under 25 years of age:

(i) who is not an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan;

(ii) who is not a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance;

(iii) who is not entitled to benefits under 42 U.S.C. 1395, et seq.; and

(iv) for whom the parent has requested coverage;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined as a dependent in the health benefit plan covering the employee.

(12) (a) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term also includes those persons eligible for coverage under 2-18-704.

(b) The term does not include an employee who works on a part-time, temporary, or substitute basis.

(13) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(14) (a) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract.

(b) The term does not include coverage of excepted benefits, as defined in 33-22-140, if coverage is provided under a separate policy, certificate, or contract of insurance.

(15) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(16) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(17) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(18) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(19) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(20) "Small employer" means a person, firm, corporation, partnership, or bona fide association that is actively engaged in business and that, with respect to a calendar year and a plan year, employed at least two but not more than 50 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed by the employer in the current calendar year. In determining the number of eligible employees, companies are considered one employer if they:

(a) are affiliated companies;

(b) are eligible to file a combined tax return for purposes of state taxation; or

(c) are members of a bona fide association.

(21) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(22) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier.

History: **En. Sec. 24, Ch. 606, L. 1993; amd. Sec. 1, Ch. 377, L. 1995; amd. Sec. 65, Ch. 379, L. 1995; amd. Sec. 21, Ch. 416, L. 1997; amd. Sec. 1, Ch. 103, L. 1999; amd. Sec. 47, Ch. 472, L. 1999; amd. Sec. 36, Ch. 469, L. 2005; amd. Sec. 6, Ch. 356, L. 2007; amd. Sec. 14, Ch. 227, L. 2011.**

33-22-1804. Applicability and scope. (1) This part applies to a health benefit plan marketed through a small employer that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(a) a portion of the premium or benefits is paid by or on behalf of the small employer;

(b) an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium;

(c) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 106, 125, or 162 of the Internal Revenue Code, except a plan or program that is funded entirely by contributions from the employees; or

(d) all of the premium is paid by the employee who obtains coverage through the employer's group health benefit plan.

(2) This part does not apply to an individual health benefit plan for which the entire premium is paid by an employee through payroll deduction or other means.

(3) Unless prohibited by a written opinion from a federal agency, by final regulations implementing Public Law 104-191, or by a ruling by a court of competent jurisdiction, this part does not apply to an individual health benefit plan if the eligible employee or dependent is directly or indirectly reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium. However, this part does apply to an individual health benefit plan if the employer making the direct or indirect reimbursement for any portion of the premium has had in place an employer-sponsored group health benefit plan in the 12 months preceding the reimbursement.

History: **En. Sec. 25, Ch. 606, L. 1993; amd. Sec. 2, Ch. 377, L. 1995; amd. Sec. 22, Ch. 416, L. 1997; amd. Sec. 1, Ch. 403, L. 1999; amd. Sec. 3, Ch. 349, L. 2013; amd. Sec. 27, Ch. 63, L. 2015.**

33-22-1805 through 33-22-1807 reserved.

33-22-1808. Establishment of classes of business. (1) A small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs that are related to the following reasons:

(a) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

(b) The small employer carrier has acquired a class of business from another small employer carrier.

(c) The small employer carrier provides coverage to one or more association groups that meet the requirements of 33-22-501(2).

(2) A small employer carrier may establish up to nine separate classes of business under subsection (1).

(3) The commissioner shall adopt rules to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the case of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that the action would enhance the fairness and efficiency of the small employer health insurance market.

History: En. Sec. 26, Ch. 606, L. 1993.

33-22-1809. Restrictions relating to premium rates. (1) Premium rates for health benefit plans under this part are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15%.

(f) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups. Differences among base premium rates may not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

(g) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in health status of the employees of small employers and the employees' dependents;

(b) the provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claims experience, that affect changes in premium rates;

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this part and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

(6) The commissioner may not require prior approval of the rating methods used by small employer carriers or the premium rates of the health benefit plans offered to small employers.

History: En. Sec. 27, Ch. 606, L. 1993; amd. Sec. 3, Ch. 377, L. 1995; amd. Sec. 9, Ch. 378, L. 1995; amd. Sec. 23, Ch. 416, L. 1997; amd. Sec. 48, Ch. 472, L. 1999; amd. Sec. 30, Ch. 271, L. 2009.

33-22-1810. Renewability of coverage. (1) A health benefit plan subject to the provisions of this part is renewable with respect to all eligible employees or their dependents, at the option of the small employer, except in any of the following cases:

(a) nonpayment of the required premium;

(b) fraud or misrepresentation of the small employer or with respect to coverage of individual insureds or their representatives;

(c) noncompliance with the carrier's minimum participation requirements;

(d) noncompliance with the carrier's employer contribution requirements;

(e) repeated misuse of a restricted network provision;

(f) election by the small employer carrier to not renew all of its health benefit plans delivered or issued for delivery to small employers in this state, in which case the small employer carrier shall:

(i) provide advance notice of this decision under this subsection (1)(f) to the commissioner in each state in which it is licensed; and

(ii) at least 180 days prior to the nonrenewal of all small employer health benefit plans by the carrier, provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside. Notice to the commissioner under this subsection (1)(f) must be provided at least 3 working days prior to the notice to the affected small employers.

(g) the commissioner finds that the continuation of the coverage would:

(i) not be in the best interests of the policyholders or certificate holders; or

(ii) impair the carrier's ability to meet its contractual obligations.

(2) If the commissioner makes a finding under subsection (1)(g), the commissioner shall assist affected small employers in finding replacement coverage.

(3) (a) A small employer carrier that elects not to renew all of its health benefit plans under subsection (1)(f) is prohibited from writing new business in the small employer market in this state for a period of 5 years from the date of notice to the commissioner.

(b) The provisions of 33-22-524(3) apply to a small employer carrier that elects to renew only a portion, but not all, of its small employer health benefit plans.

(4) In the case of a small employer carrier doing business in one established geographic service area of the state, the rules set forth in this section apply only to the carrier's operations in that service area.

History: En. Sec. 28, Ch. 606, L. 1993; amd. Sec. 61, Ch. 227, L. 2001.

33-22-1811. Availability of coverage — required plans. (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier must have approved for issuance to small employer groups at least two health benefit plans.

(b) (i) A small employer carrier shall issue all plans marketed under this part to any eligible small employer that applies for a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part.

(ii) In the case of a small employer carrier that establishes more than one class of business pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers all plans marketed under this part in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not:

(i) because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the individual's enrollment date. A health benefit plan may not define a preexisting condition exclusion more restrictively than 33-22-140.

(ii) use a preexisting condition exclusion more restrictive than exclusions allowed under 33-22-514.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time that an individual was previously covered by creditable coverage that provided benefits with respect to those services if the creditable coverage was continuous to a date not more than 63 days prior to the submission of an application for new coverage. A health benefit plan may determine waivers of time periods applicable to preexisting condition exclusions or limitations on the basis of prior coverage of benefits within each of several classes or categories as specified in regulations implementing Public Law 104-191, rather than as provided in this subsection (3)(b). This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date on which the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier. For the purpose of meeting minimum participation requirements of groups of four or more, a small employer carrier may not consider employees who, because they are covered under another health plan, waive coverage under the small employer's plan as part of the group of eligible employees. However, a small employer carrier may require at least two eligible employees to participate in a plan.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a plan marketed under this part with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan provided by the small employer. The waiver must be signed by the eligible employee and must certify that the employee was informed of the availability of coverage under the health benefit plan and of the penalties for late enrollment. The waiver may not require the eligible employee to disclose the reasons for declining coverage.

(iv) A small employer carrier may not issue coverage to a small employer if the carrier or a producer for the carrier has evidence that the small employer induced or pressured an eligible employee to decline coverage due to the health status or risk characteristics of the eligible employee or of the dependents of the eligible employee.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to an employer whose employees do not work or reside within the small employer carrier's established geographic service area for a network plan, as defined in 33-22-140; or

(ii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees. The small employer carrier may not deny coverage under this subsection unless the small employer carrier acts uniformly without regard to claims experience or health status-related factors of employers, employees, or dependents.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for which the commissioner determines that the small employer carrier does not have the financial reserves necessary to underwrite additional coverage and that the small employer carrier has denied coverage of small employers uniformly throughout the state and without regard to the claims experience and health status-related factors of the applicant small employer groups. The small employer carrier exempted from providing coverage under this subsection may not offer coverage to small employer groups in this state for 180 days after the date on which coverage is denied or until the small employer carrier has demonstrated to the commissioner that the small employer carrier has sufficient financial reserves to underwrite additional coverage, whichever is later.

History: En. Sec. 29, Ch. 606, L. 1993; amd. Sec. 4, Ch. 377, L. 1995; amd. Sec. 95, Ch. 379, L. 1995; amd. Sec. 3, Ch. 522, L. 1995; amd. Sec. 24, Ch. 416, L. 1997; amd. Sec. 1, Ch. 87, L. 1999; amd. Sec. 49, Ch. 472, L. 1999; amd. Sec. 17, Ch. 169, L. 2013.

33-22-1812. Repealed. Sec. 13, Ch. 377, L. 1995.

History: En. Sec. 31, Ch. 606, L. 1993.

33-22-1813. Standards to ensure fair marketing. (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state.

(2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of health insurance coverage for a small employer must be in writing and must state the reason or reasons for the denial.

(8) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) (a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier.

History: En. Sec. 35, Ch. 606, L. 1993; amd. Sec. 50, Ch. 472, L. 1999.

33-22-1814. Restoration of terminated coverage. The commissioner may promulgate rules to require small employer carriers, as a condition of transacting business with small employers in this state after January 1, 1994, to reissue a health benefit plan to any small employer whose health benefit plan has been terminated or not renewed by the carrier after July 1, 1993. The commissioner may prescribe the terms for the reissuance of coverage that the commissioner finds are reasonable and necessary to provide continuity of coverage to small employers.

History: En. Sec. 36, Ch. 606, L. 1993.

33-22-1815. Qualifications for voluntary purchasing pool. A voluntary purchasing pool of disability insurance purchasers may be formed solely for the purpose of obtaining disability insurance upon compliance with the following provisions:

(1) It contains at least 51 eligible employees.

(2) It establishes requirements for membership. The voluntary purchasing pool shall accept for membership any small employers and may accept for membership any employers with at least 51 eligible employees that otherwise meet the requirements for membership. However, the voluntary purchasing pool may not exclude any small employers that otherwise meet the requirements for membership on the basis of claim experience, occupation, or health status.

(3) It holds an open enrollment period at least once a year during which new members can join the voluntary purchasing pool.

(4) It offers coverage to eligible employees of member employers and to the employees' dependents. Coverage may not be limited to certain employees of member small employers except as provided in 33-22-1811(3)(c).

(5) It does not assume any risk or form self-insurance plans among its members.

(6) (a) Disability insurance policies, certificates, or contracts offered through the voluntary purchasing pool must rate the entire purchasing pool group as a whole and charge each insured person based on a community rate within the common group, adjusted for case characteristics as permitted by the laws governing group disability insurance.

(b) Rates for voluntary purchasing pool groups must be set pursuant to the provisions of 33-22-1809.

(c) At its discretion, premiums may be paid to the disability insurance policies, certificates, or contracts by the voluntary purchasing pool or by member employers.

(7) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer.

History: En. Sec. 2, Ch. 375, L. 1995; amd. Sec. 51, Ch. 472, L. 1999; amd. Sec. 1, Ch. 376, L. 2003; amd. Sec. 16, Ch. 595, L. 2005; amd. Sec. 27, Ch. 151, L. 2017.

33-22-1816. Commissioner powers and duties — application for registration — reporting insolvency. (1) The commissioner shall develop forms for registration of an organization as a voluntary purchasing pool.

(2) An organization seeking to be registered as a voluntary purchasing pool shall make application to the commissioner. The commissioner shall register an organization as a voluntary purchasing pool upon proof of fulfillment of the qualifications provided in 33-22-1815.

(3) Except as provided in subsection (5), on March 1 of each year, the voluntary purchasing pool shall provide a report and financial statement for the previous calendar year to the commissioner so that the commissioner may determine:

(a) whether the operation of the voluntary purchasing pool is fiscally sound;

(b) whether the voluntary purchasing pool is bearing any risk; and

(c) the number of individuals covered.

(4) The annual report of the voluntary purchasing pool must disclose its total administrative cost.

(5) A voluntary purchasing pool may choose to operate on a fiscal year other than on the calendar year. A voluntary purchasing pool that establishes a fiscal year that is other than the calendar year shall provide the report required in subsection (3) to the commissioner within 60 days of the voluntary purchasing pool's fiscal yearend.

History: En. Sec. 3, Ch. 375, L. 1995; amd. Sec. 52, Ch. 472, L. 1999; amd. Sec. 1, Ch. 87, L. 2009; amd. Sec. 28, Ch. 151, L. 2017.

33-22-1817. Collection of charges and premiums. (1) All insurance or premiums collected by a voluntary purchasing pool on behalf of or for an insurer and all return premiums received from the insurer are held by the voluntary purchasing pool in a fiduciary capacity. These funds must be remitted immediately to the person entitled to them or must be deposited promptly in a fiduciary bank account established and maintained by the administrator of the voluntary purchasing pool. If deposited charges or premiums are collected on behalf of or for more than one insurer, the voluntary purchasing pool shall either keep or require the bank in which the fiduciary account is maintained to keep records clearly recording the deposits to and withdrawals from the account on behalf of each insurer. The voluntary purchasing pool shall promptly obtain and keep copies of all these records and shall, upon request of an insurer, furnish the insurer with copies of the records pertaining to deposits and withdrawals on behalf of or for the insurer.

(2) The voluntary purchasing pool may not pay a claim by withdrawals from the fiduciary account. Withdrawals from the fiduciary account must be made, as provided in the written agreement between the voluntary purchasing pool and the insurer, for:

(a) remittance to an insurer entitled to the remittance;

(b) deposit in an account maintained in the name of the insurer;

(c) payment to a group policyholder for remittance to the insurer entitled to the payment; or

(d) remittance of return premiums to the person entitled to the premium.

History: En. Sec. 4, Ch. 375, L. 1995.

33-22-1818. Repealed. Sec. 3, Ch. 103, L. 1999.

History: En. Sec. 30(1)-(3), Ch. 606, L. 1993; amd. Sec. 7, Ch. 377, L. 1995; amd. Sec. 1, Ch. 15, L. 1997.

33-22-1819. Repealed. Sec. 3, Ch. 103, L. 1999.

History: En. Sec. 30(4)-(15), Ch. 606, L. 1993; amd. Sec. 8, Ch. 377, L. 1995; amd. Sec. 66, Ch. 379, L. 1995; amd. Sec. 2, Ch. 15, L. 1997; amd. Sec. 25, Ch. 416, L. 1997; amd. Sec. 35, Ch. 531, L. 1997; amd. Sec. 2, Ch. 103, L. 1999.

33-22-1820. Periodic market evaluation — report. The commissioner may study and report at least every 3 years to the governor or other interested persons on the effectiveness of this part. The report must analyze the effectiveness of this part in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small employer health insurance markets. The report must address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this part. The report may contain recommendations for market conduct or other regulatory standards or action.

History: En. Sec. 32, Ch. 606, L. 1993; amd. Sec. 9, Ch. 377, L. 1995; amd. Sec. 36, Ch. 531, L. 1997.

33-22-1821. Waiver of certain laws. A small employer carrier may exclude any category of licensed health care practitioner and any benefit or coverage for health care services otherwise required by law or rule from a basic health benefit plan delivered or issued for delivery in this state.

History: **En. Sec. 33, Ch. 606, L. 1993; amd. Sec. 10, Ch. 377, L. 1995; amd. Sec. 15, Ch. 227, L. 2011.**

33-22-1822. Administrative procedure. The commissioner shall adopt rules in accordance with the Montana Administrative Procedure Act to implement and administer this part.

History: **En. Sec. 34, Ch. 606, L. 1993.**

33-22-1823 through 33-22-1826 reserved.

33-22-1827. Repealed. Sec. 24, Ch. 227, L. 2011.

History: **En. Sec. 5, Ch. 377, L. 1995; amd. Sec. 5, Ch. 410, L. 1997; amd. Sec. 26, Ch. 416, L. 1997.**

33-22-1828. Repealed. Sec. 24, Ch. 227, L. 2011.

History: **En. Sec. 6, Ch. 377, L. 1995; amd. Sec. 27, Ch. 416, L. 1997; amd. Sec. 37, Ch. 531, L. 1997.**

Part 19

Obstetricians and Gynecologists — Primary Care Physicians

33-22-1901. Scope — purpose. The provisions of this part apply to all health benefit plans offered to persons who receive health care services in this state. The purpose of this part is to ensure that obstetricians and gynecologists may be participating primary care physicians under health benefit plans offered to patients who receive health care services in this state and that persons covered by health benefit plans have direct access to the services of a participating obstetrician or gynecologist of their choice.

History: **En. Sec. 1, Ch. 198, L. 1997.**

33-22-1902. Definitions. As used in this part, the following definitions apply:

(1) "Covered person" means a policyholder, subscriber, certificate holder, enrollee, or other individual who is participating in a health benefit plan.

(2) "Health benefit plan" means any individual or group plan, policy, certificate, subscriber contract, contract of insurance provided by a managed care plan, preferred provider agreement, or health maintenance organization subscriber contract that is issued, delivered, issued for delivery, or renewed in this state by a health carrier that pays for, purchases, or furnishes health care services to covered persons who receive health care services in this state. For the purposes of this part, a health benefit plan located or domiciled outside of the state of Montana is subject to the provisions of this part if it receives, processes, adjudicates, pays, or denies claims for health care services submitted by or on behalf of covered persons who reside or who receive health care services in the state of Montana.

(3) "Health carrier" means a disability insurer, health care insurer, health maintenance organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, health service corporation, health care service plan, preferred provider organization or arrangement, multiple employer welfare arrangement, or any other person, firm, corporation, joint venture, or similar business entity.

(4) "Obstetrician or gynecologist" means a physician who is board-eligible or board-certified by the American board of obstetrics and gynecology.

(5) "Participating obstetrician or gynecologist" means an obstetrician or gynecologist who is employed by or under contract with a health benefit plan.

(6) "Primary care physician" means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for specialist care.

History: **En. Sec. 2, Ch. 198, L. 1997.**

33-22-1903. Obstetricians or gynecologists as primary care physicians. (1) Each health benefit plan that provides coverage for primary care or obstetrical or gynecological care must allow obstetricians and gynecologists to participate as primary care physicians. The health carrier that provides the health benefit plan shall contract with a sufficient number of obstetricians and gynecologists to ensure that covered persons have access to the options under this section without unreasonable delay if there are obstetricians or gynecologists practicing in the geographic service areas in which the plan operates who are willing to participate in the plan. An obstetrician or gynecologist may not be required to accept primary care physician status if the obstetrician or gynecologist does not wish to be designated as a primary care physician. A health benefit plan must use the same criteria with regard to credentials and other selection criteria for a participating obstetrician or gynecologist as are applied by the health benefit plan with respect to other physicians who are participating in the health benefit plan. An obstetrician or gynecologist wishing to accept designation as a primary care physician must meet the same criteria with regard to credentials and other selection criteria for a participating primary care physician as other physicians who are participating as primary care physicians in the health benefit plan.

(2) Each health benefit plan must allow a covered person to select any participating obstetrician or gynecologist of the covered person's choice as the covered person's primary care physician.

History: **En. Sec. 3, Ch. 198, L. 1997.**

33-22-1904. Self-referral for obstetrical or gynecological care permitted. (1) A health benefit plan must permit self-referral to any participating obstetrician or gynecologist by a covered person who has not selected a participating obstetrician or gynecologist as the covered person's primary care physician for services covered under the health benefit plan. This self-referral is for the purpose of receiving any obstetrical or gynecological examination or care and primary and preventative obstetrical and gynecological services required as a result of any obstetrical or gynecological examination or condition. This self-referral must be allowed without prior authorization or precertification from the health benefit plan or covered person's primary care physician, but the health benefit plan may require the covered person to notify the plan prior to self-referral.

(2) The services covered by this section may be limited to those services defined by the most recent published recommendations of the American college of obstetricians and gynecologists. The self-referral permitted by this section may be limited to one participating obstetrician or gynecologist for obstetrical care and one participating obstetrician or gynecologist for gynecological care of the covered person's choice annually.

(3) The participating obstetrician or gynecologist and the covered person shall comply with the health benefit plan's coordination and referral policies. The health benefit plan may require the participating obstetrician or gynecologist to whom the covered person self-refers to discuss with the covered person's primary care physician any services or treatment the participating obstetrician or gynecologist recommends for the covered person.

(4) Self-referral under this section may not affect the covered person's coverage under the health benefit plan. It is the intent of this section that a covered person must at all times have direct access to the covered services of the participating obstetrician or gynecologist of the covered person's choice under any health benefit plan.

History: **En. Sec. 4, Ch. 198, L. 1997.**

33-22-1905. Surcharges not allowed. A health benefit plan may not impose a surcharge or additional copayments or deductibles upon a covered person who seeks or receives health care services under 33-22-1903 or 33-22-1904 unless similar surcharges or additional copayments or deductibles are imposed for other types of health care services not described in 33-22-1903 and 33-22-1904.

History: **En. Sec. 5, Ch. 198, L. 1997.**

33-22-1906. Payment of covered services provided by certified advanced practice registered nurses. A health benefit plan may not deny payment for covered services provided to a covered person under 33-22-1903 and 33-22-1904 by a certified advanced practice registered nurse practicing in collaboration with the participating obstetrician or gynecologist. This section may not be construed to expand the definitions of participating obstetrician or gynecologist or primary care physician in 33-22-1902 to include certified advanced practice registered nurses.

History: **En. Sec. 6, Ch. 198, L. 1997.**

33-22-1907. Disclosure. Each health benefit plan shall disclose in all of its plan literature, in clear, accurate language, the covered person's option to seek the care described in this part without preapproval, preauthorization, or referral.

History: **En. Sec. 7, Ch. 198, L. 1997.**

33-22-1908. Enforcement. If the commissioner determines that a health benefit plan does not comply with this part or that a health carrier has not complied with a provision of this part, the commissioner may:

(1) recommend a correction plan that must be followed by the health carrier;

(2) institute corrective action that must be followed by the health carrier;

(3) suspend or revoke the certificate of authority or deny the health carrier's application for a certificate of authority; or

(4) use any of the commissioner's enforcement powers to obtain the health carrier's compliance with this part.

History: En. Sec. 8, Ch. 198, L. 1997.

Part 20
Small Business Health Insurance Purchasing Pool (Repealed)

33-22-2001. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 1, Ch. 595, L. 2005; amd. Sec. 38, Ch. 44, L. 2007; amd. Sec. 17, Ch. 399, L. 2007.

33-22-2002. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 2, Ch. 595, L. 2005; amd. Sec. 18, Ch. 399, L. 2007; amd. Sec. 16, Ch. 227, L. 2011; amd. Sec. 18, Ch. 169, L. 2013.

33-22-2003. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 3, Ch. 595, L. 2005.

33-22-2004. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 4, Ch. 595, L. 2005; amd. Sec. 19, Ch. 399, L. 2007; amd. Sec. 2, Ch. 87, L. 2009; amd. Sec. 17, Ch. 227, L. 2011; amd. Sec. 1, Ch. 331, L. 2013.

33-22-2005. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 5, Ch. 595, L. 2005.

33-22-2006. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 6, Ch. 595, L. 2005; amd. Sec. 3, Ch. 87, L. 2009; amd. Sec. 18, Ch. 227, L. 2011; amd. Sec. 2, Ch. 331, L. 2013.

33-22-2007. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 7, Ch. 595, L. 2005; amd. Sec. 4, Ch. 87, L. 2009; amd. Sec. 3, Ch. 331, L. 2013.

33-22-2008. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 8, Ch. 595, L. 2005; amd. Sec. 5, Ch. 87, L. 2009; amd. Sec. 19, Ch. 227, L. 2011; amd. Sec. 4, Ch. 331, L. 2013.

33-22-2009. Repealed. Sec. 54, Ch. 151, L. 2017.

History: En. Sec. 9, Ch. 595, L. 2005; amd. Sec. 29, Ch. 396, L. 2017.

Part 21
Fertility Preservation Services

33-22-2101. Legislative findings — purpose. (1) The legislature finds that young Montanans who are diagnosed with cancer often learn, shortly before they are to begin the medical treatment needed to save their lives, that the treatment may result in infertility, leaving them only a small window of time in which to decide whether to undergo medically necessary efforts to preserve their ability to have biological families.

(2) The legislature further finds that future fertility is a top quality of life priority for many young cancer patients and that the possibility of infertility may cause significant distress and grief during a time when cancer patients are also facing not only their diagnoses but also the prospects of treatment that may include surgery, chemotherapy, radiation, or a combination of those approaches.

(3) The legislature further finds that fertility preservation is medically necessary and considered part of the standard of care for age-eligible oncology patients.

(4) It is the intent of this part to ensure that fertility preservation services for cancer patients are covered by insurance plans in the same manner as other medically necessary care and that cancer patients are made aware of the options for fertility preservation services.

History: En. Sec. 1, Ch. 782, L. 2023.

33-22-2102. Definitions. As used in this part, the following definitions apply:

(1) "Iatrogenic infertility" means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

(2) "Medical treatment that may directly or indirectly cause iatrogenic infertility" means treatment with a potential side effect of impaired fertility, as established by a national association for practitioners of reproductive medicine or clinical oncology.

(3) "Standard fertility preservation services" means procedures consistent with established medical practices and professional guidelines published by a national association for practitioners of reproductive medicine or clinical oncology.

History: En. Sec. 2, Ch. 782, L. 2023.

33-22-2103. Coverage of fertility preservation services. (1) Each individual and group disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state that provides coverage for hospital, medical, or surgical services must cover medically necessary costs for standard fertility preservation services when an insured member is diagnosed with cancer and the standard of care involves medical treatment that may directly or indirectly cause iatrogenic infertility.

(2) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions. Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to other hospital, medical, or surgical services covered under the plan may not be imposed on coverage for fertility preservation services.

(3) This section does not apply to disability income, hospital indemnity, accident-only, vision, dental, or long-term care policies.

History: En. Sec. 3, Ch. 782, L. 2023.

33-22-2104. Renumbered 53-6-2210. Sec. 33, Ch. 8, L. 2025.

Part 22
Dental Insurance Transparency and Accountability Act

Part Compiler's Comments

Effective Date: Section 8, Ch. 600, L. 2025, provided that this part is effective June 1, 2025.

Applicability: Section 9, Ch. 600, L. 2025, provided: "[This act] applies to dental insurance policies, plans, contracts, and certificates issued or renewed on or after January 1, 2026."

33-22-2201. Short title — purpose — scope — exceptions. (1) This part may be cited as the "Montana Dental Insurance Transparency and Accountability Act".

(2) The purpose of this part is to:

(a) require that dental insurance coverage has a medical loss ratio that is transparent to the public and fair to covered individuals; and

(b) provide for transparency of the expenditure of dental health care plan premiums and to require annual reports and remediation if the dental loss ratio falls below a certain percentage.

(3) The provisions of this part apply to all policies and certificates of individual and group dental insurance offered to, renewed for, or issued to Montana residents by a disability insurer offering dental coverage.

(4) This part does not apply to health insurance coverage that has dental benefits imbedded in the plan in addition to other medical benefits and is subject to the minimum medical loss ratio requirements of Public Law 111-148, the Patient Protection and Affordable Care Act.

(5) This part does not apply to dental care services covered under medicaid or the healthy Montana kids plan provided for in Title 53, chapter 4, part 11.

History: En. Sec. 1, Ch. 600, L. 2025.

33-22-2202. Definitions. As used in this part, the following definitions apply:

(1) (a) "Dental insurer" means an insurance company licensed to do business in the state that offers coverage for dental services, including excepted benefits as defined in 33-22-140.

(b) The term does not include health insurance coverage described in 33-22-2201(4).

(2) "Dental loss ratio" means the percentage of premium dollars spent on patient care as calculated pursuant to subsection (3)(b)(i).

(3) (a) "Medical loss ratio" is the minimum percentage of all premium funds collected by an insurer each year that must be spent on actual patient care rather than overhead costs.

(b) The dental loss ratio is calculated by dividing the numerator by the denominator, in which:

(i) the numerator is the sum of the amount incurred for clinical dental services provided to enrollees, the amount incurred on activities that improve dental care quality, and other incurred claims as defined in 45 CFR 158.140(a); and

(ii) the denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, nonprofit community benefit expenditures as defined in 45 CFR 158.162(c), and any other payments required by federal law.

History: **En. Sec. 2, Ch. 600, L. 2025.**

33-22-2203. Transparency of dental insurance premiums. (1) A dental insurer that issues, sells, or renews a plan, policy, contract, or certificate covering dental services shall file by March 1 of each year with its annual statement a medical dental loss ratio report with the commissioner of securities and insurance that is organized by market and product type and contains similar information required in the 2013 federal medical loss ratio annual reporting form. The filing must also report additional data that includes the number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

(2) (a) The dental loss ratio reporting year must be for the policy year during which dental coverage is provided by the insurer. All terms used in the dental loss ratio annual report have the same meaning as used in the federal Public Health Service Act, 42 U.S.C. 300gg-18, and 45 CFR, part 158.

(b) If data verification of the dental insurer's representations in the dental loss ratio annual report is considered necessary, the commissioner shall provide the dental insurer with a notification of the additional information needed within 30 days.

(c) The dental insurer has 30 days from the date of notification to submit to the commissioner all requested data. The commissioner may extend the time for a dental insurer to comply with this subsection (2)(c) on a finding of good cause.

(3) By January 1 of the year after the commissioner receives the dental loss ratio information collected pursuant to this part, the commissioner shall make the information, including the aggregate dental loss ratio and other data reported pursuant to this section, available to the public in a searchable format on a public website that allows members of the public to compare dental loss ratios among insurers by plan type. The commissioner shall accomplish this by posting the information on the department's website.

(4) The commissioner shall report biennially the data in this section to the economic affairs interim committee in accordance with 5-11-210.

History: **En. Sec. 3, Ch. 600, L. 2025.**

33-22-2204. Excess revenue — rebate. (1) The commissioner shall aggregate dental loss ratios for each dental insurer by year pursuant to 33-22-2203 for each market segment in which the dental insurer operates. The commissioner shall calculate an average dental loss ratio for each market segment using aggregate data for a 3-year period, including data for the most recent dental loss ratio reporting year and the data for the two prior dental loss ratio reporting years. Newer experience is subject to reporting standards specified in 45 CFR 158.121.

(2) (a) The commissioner shall calculate an average dental loss ratio for each market segment using the data pursuant to subsection (1), identify as outliers dental plans that fall outside 1 standard deviation of the average dental loss ratio, and report those plans to the legislature as provided in 33-22-2203(4).

(b) A dental insurer may not be considered an outlier if its dental loss ratio in a market segment is within 3 percentage points of the average dental loss ratio. A higher threshold may be set in unique circumstances as determined reasonable by the commissioner.

(3) The commissioner shall investigate dental insurers that report a dental loss ratio lower than 1 standard deviation from the mathematical average and may take remediation or

enforcement actions against them, including ordering them to rebate, in a manner consistent with 45 CFR, part 158, subpart B, all premiums paid above the amounts that would have caused the dental insurer to have achieved the mathematical average of the data submitted in a given year for a given market segment.

(4) The report in subsection (2) is organized to show year-over-year changes in a dental insurer's outlier status relative to meeting the 1 standard deviation outlier standard in subsection (2). If the dental loss ratio for a dental insurer in a market segment does not increase and remains an outlier as described in subsection (2) after 2 consecutive years, barring unique circumstances as determined reasonable by the commissioner, the dental insurer is subject to a minimum dental loss ratio percentage by market segment. The commissioner shall promulgate rules establishing the dental loss ratio percentage based on, at minimum, the average of existing dental insurer loss ratios by market segment in the state to be effective no sooner than 42 months after a dental insurer is determined to be an outlier.

(5) A dental insurer subject to remediation in subsections (3) and (4) shall provide any rebate owing to a policyholder no later than August 1 of the fiscal year following the year for which the ratio described in subsection (1) was calculated. The commissioner may establish alternatives to direct rebates to include premium reductions in the following benefit year.

(6) The commissioner may promulgate rules that create a process to identify dental insurers that increase rates in excess of the percentage increase of the latest dental services consumer price index as reported through the bureau of labor statistics of the United States department of labor.

History: **En. Sec. 4, Ch. 600, L. 2025.**

33-22-2205. Rulemaking. (1) The commissioner of securities and insurance shall adopt rules to implement the provisions of this part.

(2) (a) The commissioner shall define by rule:

(i) expenditures for clinical dental services;

(ii) activities that improve dental care quality; and

(iii) overhead and administrative cost expenditures.

(b) Activities conducted by an issuer intended to improve dental care quality may not exceed 5% of net premium revenue.

(3) The definitions promulgated by rule pursuant to this section must be consistent with similar definitions that are used for the reporting of medical loss ratios by insurers offering health insurance coverage in the state. Overhead and administrative costs may not be included in the numerator.

History: **En. Sec. 5, Ch. 600, L. 2025.**

CHAPTER 23
CASUALTY INSURANCE

Part 1 — General Provisions

33-23-101. Repealed.
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33-23-222. Telematics agreement disclosures.
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33-23-301. Cancellation or increase of premium rates by reason of unfounded claims prohibited.
33-23-302. Cancellation or alteration of policy — increase of premium rates — written notice required.
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33-23-312. Cancellation or nonrenewal of all policies.

Part 4 — Homes

33-23-401. Written notice required for cancellation or nonrenewal of insurance policies on homes.

Part 5 — Medical Malpractice Insurance Joint Underwriting Association (Repealed)

Chapter Cross-References

Horseraces and race meets — public liability insurance required, 23-4-205.
Premium changes and cancellation of casualty insurance, Title 33, ch. 15, part 11.
Apportionment of casualty insurance — rating groups — pooling, 33-16-305.
Destruction of property to defraud insurer — crime, 45-6-101.
Fire losses — information available to state agencies, 50-63-401.
Suspicious fires — report, 50-63-402.
Transfer of ownership of vehicles by insurance company, 61-3-205.
Physicians, nurses, and hospitals — liens on personal injury claims, Title 71, ch. 3, part 11.

Part 1
General Provisions

33-23-101. Repealed. Sec. 4, Ch. 425, L. 1979.

History: En. Sec. 411, Ch. 286, L. 1959; amd. Sec. 5, Ch. 234, L. 1977; R.C.M. 1947, 40-4401.

33-23-102. Existence of insurance not to be made evident. No attempt may be made in the trial of an action brought against a political subdivision of the state, municipality, or any public body, corporation, commission, board, agency, organization, or other public entity to suggest the existence of any insurance which covers in whole or in part any judgment or award which may be rendered in favor of plaintiff.

History: En. Sec. 1, Ch. 240, L. 1963; amd. Sec. 6, Ch. 234, L. 1977; R.C.M. 1947, 40-4402; amd. Sec. 1, Ch. 425, L. 1979.

33-23-103. Casualty insurance policy — conformity with state statutes. A casualty insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision or the equivalent thereto as follows:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

History: En. Sec. 23, Ch. 798, L. 1991.

Part 2
Motor Vehicle Liability

Part Cross-References

Attorney fees — motor vehicle claim, 25-10-303.
Collateral source reductions in actions arising from bodily injury or death — subrogation rights, 27-1-308.
Denial of insurance — credit report — consumer's rights, 31-3-131.
Discrimination in insurance and retirement plans, 49-2-309.
Motor vehicle — transfer of ownership by insurer, 61-3-205.
Motor vehicle liability policy defined — minimum limits, 61-6-103.
Motor vehicle registration — liability insurance required, Title 61, ch. 6, part 3.
Family member exclusion, 61-6-301.
Motor club service companies — insurance and services, Title 61, ch. 12, part 3.

33-23-201. Motor vehicle liability policies to include uninsured motorist coverage — rejection by insured. (1) A motor vehicle liability policy insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of the ownership, maintenance, or use of a motor vehicle may not be delivered or issued for delivery in this state, with respect to any motor vehicle registered and principally garaged in this state, unless coverage is provided in the policy or supplemental to the policy, in limits for bodily injury or death set forth in 61-6-103, under provisions filed with and approved by the commissioner, for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, or disease, including death, resulting from the injury, sickness, or disease, caused by an accident arising out of the operation or use of the motor vehicle. An uninsured motor vehicle is a land motor vehicle, the ownership, the maintenance, or the use of which is not insured or bonded for bodily injury liability at the time of the accident.

(2) The named insured has the right to reject the coverage. Unless the named insured requests the coverage in writing, the coverage need not be provided in or supplemental to a renewal policy when the named insured had rejected the coverage in connection with the policy previously issued to the named insured by the same insurer.

History: **En. Sec. 1, Ch. 31, L. 1967; amd. Sec. 2, Ch. 526, L. 1975; R.C.M. 1947, 40-4403; amd. Sec. 7, Ch. 139, L. 1987; amd. Sec. 40, Ch. 83, L. 1989; amd. Sec. 1233, Ch. 56, L. 2009.**

Cross-References

Approval of forms by Commissioner, Title 33, ch. 1, part 5.

Claims by insureds or third parties against insolvent insurers, 33-2-1367.

33-23-202. Reimbursement for total loss of motor vehicle based on actual replacement value. Each motor vehicle insurance policy issued to residents of this state that provides that reimbursement for total loss of a motor vehicle be based on a "book" value rather than on the actual replacement value is void as to that provision, and reimbursement must be made for actual replacement value except as provided in 27-1-306.

History: **En. Sec. 1, Ch. 182, L. 1969; R.C.M. 1947, 40-4404; amd. Sec. 8, Ch. 139, L. 1987; amd. Sec. 2, Ch. 71, L. 1997.**

33-23-203. Limitation of liability under motor vehicle liability policy. (1) Unless a motor vehicle liability policy specifically provides otherwise, the limits of insurance coverage available under each part of the policy must be determined as follows, regardless of the number of motor vehicles insured under the policy, the number of policies issued by the same company covering the insured, or the number of separate premiums paid:

(a) the limits of insurance coverages available for any one accident are the limits specified for each coverage available under the policy insuring the motor vehicle involved in the accident;

(b) if the motor vehicle involved in the accident is not insured under a policy, the limits of the insurance coverages available for any one accident are the highest limits of the coverages specified under one policy for one motor vehicle insured under that policy; and

(c) the limits of the coverages specified under one policy or under more than one policy issued by the same company may not be added together to determine the limits of insurance coverages available under the policy or policies for any one accident if the premiums charged for the coverage by the insurer actuarially reflect the limiting of coverage separately to the vehicles covered by the policy and the premium rates have been filed with the commissioner.

(2) A motor vehicle liability policy may also provide for other reasonable limitations, exclusions, reductions of coverage, or subrogation clauses that are designed to prevent duplicate payments for the same element of loss under the motor vehicle liability policy or under another casualty policy that provides coverage for an injury that necessitates damages or benefit payments or to prevent the adding together of insurance coverage limits in one policy or from more than one policy issued by the same company.

(3) An insurer that charges a premium for a specified coverage shall clearly inform or notify the insured in writing of the limits of the coverage with respect to the premium charged and whether the coverage from one policy or motor vehicle may be added to the coverage of another policy or motor vehicle.

(4) This section is not intended to create coverage for a motor vehicle that would otherwise be uninsured.

History: **En. Sec. 1, Ch. 212, L. 1981; amd. Sec. 9, Ch. 139, L. 1987; amd. Sec. 1, Ch. 263, L. 1997; amd. Sec. 1, Ch. 495, L. 1997; amd. Sec. 1, Ch. 201, L. 2007.**

33-23-204. Definitions. As used in this part, the following definitions apply:

(1) (a) "Motor vehicle" means a vehicle propelled by its own power and designed primarily to transport persons or property on the highways of the state.

(b) The term does not include a bicycle or a moped, as defined in 61-8-102, an electric personal assistive mobility device, as defined in 61-1-101, or a motorized nonstandard vehicle, as defined in 61-1-101.

(2) "Motor vehicle liability policy" means a policy of automobile or motor vehicle insurance against liability required under Title 61, chapter 6, parts 1 and 3, and all additional coverages included in or added to the policy by rider, endorsement, or otherwise, whether or not required under Title 61, including, without limitation, uninsured, underinsured, and medical payment coverages.

History: **En. Sec. 6, Ch. 139, L. 1987; amd. Sec. 2, Ch. 495, L. 1997; amd. Secs. 5, 11, 12, Ch. 468, L. 2005; amd. Sec. 38, Ch. 542, L. 2005; amd. Sec. 2, Ch. 374, L. 2015.**

33-23-205 through 33-23-210 reserved.

33-23-211. Limitations on basis for cancellation. (1) A notice of cancellation of a motor vehicle liability policy is effective only if it is based on one or more of the following reasons:

(a) nonpayment of premium; or

(b) the driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates a motor vehicle insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the 180 days immediately preceding its effective date.

(2) This section does not apply to any policy or coverage which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(3) Modification of motor vehicle physical damage coverage by the inclusion of a deductible not exceeding $100 may not be deemed a cancellation of the coverage or of the policy.

(4) This section does not apply to nonrenewal of a motor vehicle liability policy.

History: **En. Sec. 3, Ch. 262, L. 1971; R.C.M. 1947, 40-4407; amd. Sec. 10, Ch. 139, L. 1987.**

Cross-References

Revocation or suspension of driver's license, Title 61, ch. 5, part 2.

33-23-212. Notice required for cancellation — statement that insurer will specify reason upon request — exception. (1) A cancellation by an insurer of a motor vehicle liability insurance policy is not effective prior to the mailing or delivery to the named insured, at the address shown in the policy, of a written notice of the cancellation stating the date on which, not less than 45 days after the date of the mailing or delivery, the cancellation becomes effective. Other provisions of this code may not be construed as affecting the requirements provided in this subsection (1).

(2) A notice of cancellation of a policy to which 33-23-211 applies is not effective unless mailed or delivered by the insurer to the named insured at least 45 days prior to the effective date of cancellation. However, if cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason must be given. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation must state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than 21 days prior to the effective date of cancellation, the insurer shall specify the reason for the cancellation.

(3) Subsection (2) does not apply to nonrenewal.

History: **En. Secs. 1, 4, 7, Ch. 262, L. 1971; R.C.M. 1947, 40-4405, 40-4408, 40-4411; amd. Sec. 11, Ch. 139, L. 1987; amd. Sec. 41, Ch. 83, L. 1989; amd. Sec. 53, Ch. 472, L. 1999; amd. Sec. 4, Ch. 339, L. 2003; amd. Sec. 43, Ch. 380, L. 2003.**

33-23-213. Notice to insured of ground for cancellation — commissioner to ensure compliance. Whenever an insurer gives notice of cancellation of a motor vehicle liability policy, upon request of the insured, the insurer, within 15 days of receipt of the request, shall furnish to the insured a statement setting forth the ground or grounds upon which the notice of cancellation is based. If the insurer fails to comply with the provisions of this section, the insured may apply to the commissioner for a certificate of the facts or information desired. The commissioner shall exercise any power conferred upon the commissioner by law that may be necessary to ensure compliance with this section.

History: En. Sec. 2, Ch. 262, L. 1971; R.C.M. 1947, 40-4406; amd. Sec. 12, Ch. 139, L. 1987; amd. Sec. 1234, Ch. 56, L. 2009.

Cross-References

Hearings by Commissioner, 33-1-701.

33-23-214. Advance notice required for nonrenewal — exceptions. (1) An insurer shall renew a motor vehicle liability policy unless it mails or delivers to the named insured, at the address shown in the policy, at least 45 days' advance notice of its intention not to renew. The notice must contain or be accompanied by a statement that upon written request made not later than 1 month following the termination date of the policy of the named insured mailed or delivered to the insurer, the insurer will notify the insured in writing, within 15 days of the insured's request, of the reason or reasons for the nonrenewal.

(2) Notwithstanding the failure of an insurer to comply with this section, the motor vehicle liability policy must terminate on the effective date of any other replacement or succeeding motor vehicle liability policy procured by the insured with respect to any motor vehicle designated in both policies.

(3) This section does not apply where the named insured has failed to discharge when due any of the insured's obligations in connection with the payment of premiums for the policy or the renewal of the policy or any installment payments for the policy, whether payable directly to the insurer or its insurance producer or indirectly under any premium finance plan or extension of credit.

(4) This section does not apply in any of the following cases:

(a) if the insurer has manifested its willingness to renew;

(b) in case of nonpayment of premium. However, notwithstanding the failure of an insurer to comply with this section, the policy must terminate on the effective date of any other insurance policy with respect to any motor vehicle designated in both policies.

(c) if the insured's insurance producer or broker has secured other coverage acceptable to the insured at least 20 days prior to the anniversary date of the policy or termination of the policy period.

(5) Renewal of a motor vehicle liability policy does not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of the renewal.

(6) A notice of nonrenewal of a motor vehicle liability policy under this section, for a policy that has a term of less than 6 months, is effective only when based on one or more of the reasons listed in 33-23-211.

History: En. Sec. 5, Ch. 262, L. 1971; amd. Sec. 1, Ch. 249, L. 1975; R.C.M. 1947, 40-4409; amd. Sec. 13, Ch. 139, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 5, Ch. 339, L. 2003.

33-23-215. No liability for statements in connection with cancellation or nonrenewal. There may be no liability on the part of and no cause of action of any nature may arise against the commissioner or against any insurer, its authorized representative, its insurance producers, its employees, or any firm, person, or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal for any statement made by any of them in any written notice of cancellation or nonrenewal or for statements made or evidence submitted at any hearings conducted in connection therewith.

History: En. Sec. 8, Ch. 262, L. 1971; R.C.M. 1947, 40-4412; amd. Sec. 14, Ch. 139, L. 1987; amd. Sec. 1, Ch. 713, L. 1989.

Cross-References

State subject to suit unless exempted by two-thirds vote of each house of Legislature, Art. II, sec. 18, Mont. Const.

Hearings by Commissioner, 33-1-701.

Insurance information and privacy protection, Title 33, ch. 19.

33-23-216. Retention and proof of notice. (1) A notice of cancellation or of intention not to renew or of reasons for cancellation of insurance issued under terms of this chapter must be retained for a period of 3 years by the insurer or the insurer's insurance producer within this state and must be made available within this state for examination or inspection by the commissioner or the insurer's insurance producers at any time within the 3-year period upon reasonable notice.

(2) Proof of mailing of notice of cancellation or of intention not to renew or of reasons for cancellation to the named insured at the address shown in the policy or to the named insured's last-known address is sufficient proof of notice.

History: **En. Sec. 6, Ch. 262, L. 1971; amd. Sec. 2, Ch. 469, L. 1977; R.C.M. 1947, 40-4410; amd. Sec. 15, Ch. 139, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1235, Ch. 56, L. 2009.**

33-23-217. Return of unearned premiums. If an insurer cancels a motor vehicle policy covering a commercial or private motor vehicle for nonpayment of a premium, the insurer shall process the cancellation on a pro rata basis. The insurer shall return whatever gross unearned premium is due under the motor vehicle policy to the insured. For purposes of this section, the term "unearned premium" means that part of the original premium, including deposits, not yet earned by the insurer and therefore due the insured if the policy is canceled.

History: **En. Sec. 1, Ch. 121, L. 1987.**

33-23-218 through 33-23-220 reserved.

33-23-221. Definitions. As used in 33-23-221 through 33-23-226, the following definitions apply:

(1) "Benefit" means any rebate, discount, abatement, credit, reduction of premium, or other advantage to the policyholder provided under the terms of a telematics agreement.

(2) "Policyholder" means a person who is a present named insured in a motor vehicle liability policy as defined in 33-23-204.

(3) "Recorded data" means the data collected, stored, or transmitted by a recording device identifying performance or operation information about a motor vehicle including:

(a) speed;

(b) direction;

(c) location; and

(d) internal controls and diagnostics, such as steering performance, brake performance, or computer diagnostics.

(4) "Recording device" means a device, mechanism, or system installed in or used in conjunction with a motor vehicle that collects, stores, or transmits recorded data. The term includes the following to the extent that they involve recorded data:

(a) event data recorders;

(b) sensing and diagnostic modules;

(c) electronic control modules;

(d) automatic crash notification systems;

(e) geographic information systems;

(f) cellular phones;

(g) personal digital assistants; and

(h) any other device that collects, stores, or transmits recorded data.

(5) "Telematics agreement" means a written agreement between an insurer and a policyholder of the insurer regarding use of a recording device in a motor vehicle to collect or store recorded data or transmit recorded data to the insurer or to a third party designated by the insurer.

History: **En. Sec. 1, Ch. 304, L. 2015.**

33-23-222. Telematics agreement disclosures. (1) A telematics agreement must be signed by the policyholder.

(2) A telematics agreement must disclose the following:

(a) if the insurer or a third party designated by the insurer provides the recording device, the categories of recorded data the recording device is capable of collecting, storing, or transmitting;

(b) the identification of any third party that may collect, store, transmit, or receive the recorded data in relation to the terms of the telematics agreement;

(c) the categories of recorded data that may be collected, stored, or transmitted;

(d) the purposes for which the insurer or a third party may use the recorded data;

(e) the length of time the insurer or third party may collect, store, transmit, or otherwise retain the data; and

(f) the terms of any benefit associated with the telematics agreement.

History: **En. Sec. 2, Ch. 304, L. 2015.**

33-23-223. Insurer obligations for telematics agreement — termination. (1) An insurer may provide a benefit to a policyholder for participating in a telematics agreement.

(2) Except as provided in subsection (4), an insurer may not cancel, refuse to issue, or refuse to renew a motor vehicle insurance policy solely because a policyholder refuses to:

(a) enter into or consent to a telematics agreement; or

(b) provide access to recorded data from a recording device.

(3) An insurer:

(a) may not reduce coverage, increase a premium, place in a less favorable rate tier, or deny a claim to a policyholder if the policyholder refuses to enter into or consent to a telematics agreement, except as provided in subsection (4) or (7); and

(b) may not, based upon analysis of recorded data collected in connection with the telematics agreement, reduce coverage, increase a premium, place in a less favorable rate tier, deny a claim, or reduce or refuse to provide a benefit to a policyholder, except as provided in subsections (4), (5), and (7).

(4) Subsections (2) and (3) do not apply to a motor vehicle insurance policy:

(a) based upon the policyholder driving a minimum or maximum number of miles or driving within a certain range of miles; and

(b) that requires a policyholder to use a recording device for purposes of determining mileage.

(5) An insurer may adjust the benefit provided under subsection (1) to the extent that an analysis of the recorded data collected through the telematics agreement accurately represents the policyholder's driving habits.

(6) An insurer offering a telematics agreement shall offer all its policyholders under that policy type an equal opportunity to enter into a telematics agreement except to the extent the recording device used under the telematics agreement is not compatible with the motor vehicle of the policyholder.

(7) (a) An insurer may terminate a telematics agreement and any associated benefit if a policyholder materially fails to comply with a term of the telematics agreement.

(b) Termination of a telematics agreement and any associated benefit under this subsection (7) does not constitute a midterm premium increase as provided in 33-15-1108.

(8) An insurer shall terminate a telematics agreement and any associated benefit upon the request of the policyholder.

History: **En. Sec. 3, Ch. 304, L. 2015.**

33-23-224. Ownership of data. Recorded data collected, stored, or transmitted by a recording device under a telematics agreement:

(1) is personal information as defined in 33-19-104; and

(2) may not be used by an insurer or third party named in the telematics agreement for uses other than those disclosed in the telematics agreement.

History: **En. Sec. 4, Ch. 304, L. 2015.**

33-23-225. Application — exclusion. (1) The provisions of 33-23-221 through 33-23-226 apply to a telematics agreement entered into between a policyholder and an insurer.

(2) The provisions of 33-23-221 through 33-23-226 do not apply to a manufacturer of a motor vehicle or supplier of an aftermarket device or services or to its respective subsidiaries or affiliates that embed in or provide a recording device for a motor vehicle as long as the manufacturer or supplier or the respective subsidiaries or affiliates is not acting as an insurer.

History: **En. Sec. 5, Ch. 304, L. 2015.**

33-23-226. Rulemaking. The commissioner may adopt rules necessary to implement the provisions of 33-23-221 through 33-23-226.

History: **En. Sec. 6, Ch. 304, L. 2015.**

Part 3
Professional Liability

Part Cross-References

Professional liability insurance, Title 33, ch. 9, part 1.
Professional licensing — medical practitioners, Title 37, ch. 3 through 12, 17, 18.
Discrimination in insurance and retirement plans, 49-2-309.

33-23-301. Cancellation or increase of premium rates by reason of unfounded claims prohibited. Whenever an action for damages is filed against or a claim or demand for damages is made to an insurer of a physician and surgeon, dentist, registered nurse, nursing home administrator, licensed physical therapist, podiatrist, psychologist, osteopath, chiropractor, pharmacist, optometrist, or veterinarian, duly licensed as such under the laws of this state, or against a licensed hospital or long-term care facility as the employer of any such person, in an action, claim, or demand for error, omission, professional negligence, or performance of services without consent, and such action, claim, or demand is later determined to be unfounded and no payment is made by the insurer to the claimant on behalf of such licensee or licensed hospital or long-term care facility or is finally determined to establish nonliability to plaintiff by such licensee or licensed hospital or long-term care facility, the fact of such litigation, claim, or demand shall not be a ground for cancellation or for any increase in insurance premium rates of the professional liability insurance during the term of the policy.

History: En. Sec. 1, Ch. 210, L. 1971; amd. Sec. 1, Ch. 303, L. 1973; R.C.M. 1947, 40-4413.

Cross-References

Montana Medical Legal Panel Act, Title 27, ch. 6.

33-23-302. Cancellation or alteration of policy — increase of premium rates — written notice required. Any insurer who insures a person licensed in the practice of medicine, as defined in 37-3-102, a dentist, registered nurse, nursing home administrator, registered physical therapist, podiatrist, licensed psychologist, osteopath, chiropractor, pharmacist, optometrist, or veterinarian, licensed under the laws of this state, or a licensed hospital or long-term care facility as the employer of any person identified in this section against liability for error, omission, professional negligence, or performance of services without consent may not cancel or alter the policy insuring the person or increase the premium rates on the policy without first providing the insured 60 days' written notice of the insurer's intention to cancel or alter the policy or increase the premium rates.

History: En. Sec. 1, Ch. 14, L. 1971; amd. Sec. 2, Ch. 303, L. 1973; R.C.M. 1947, 40-4414; amd. Sec. 18, Ch. 798, L. 1991; amd. Sec. 6, Ch. 339, L. 2003.

33-23-303 through 33-23-309 reserved.

33-23-310. Medical malpractice insurance report by insurer. (1) If requested in writing by the commissioner, each insurer engaged in issuing medical malpractice professional liability insurance in this state shall, within 60 days, provide a report to the commissioner containing the following categories of information, as directed by the commissioner, for one or more professions provided in subsection (2)(b):

(a) the number of medical malpractice insureds as of December 31 of the preceding calendar year;

(b) the amount of direct premiums written and direct premiums paid for medical malpractice insurance during the preceding calendar year;

(c) the number of medical malpractice claims made against its insureds during the preceding calendar year;

(d) the number of medical malpractice claims that were closed and that had a direct loss paid during the preceding calendar year, together with the total amount of direct losses paid for all closed claims for that year;

(e) the number of medical malpractice claims that were still open and had no direct losses paid as of December 31 of the preceding calendar year;

(f) the number of claims filed against its insureds in state and federal courts during the preceding calendar year, including the number of claims that were closed:

(i) without settlement during the preceding calendar year;

(ii) with a settlement during the preceding calendar year and the total amount paid for those claims;

(iii) during the preceding calendar year and that went to trial and the number that resulted in a judgment or verdict for the plaintiff, the number that resulted in a judgment or verdict for the insured, and the number that resulted in some other judgment or verdict;

(g) the total direct losses paid for claims against its medical malpractice insureds that went to trial and were closed during the preceding year; and

(h) other information and statistics that the commissioner of insurance requires.

(2) For purposes of this section:

(a) "insurer" has the meaning provided in 33-1-201; and

(b) "profession" includes the categories of physician, osteopath, podiatrist, dentist, optometrist, registered nurse, licensed practical nurse, or health care facility as defined in 50-5-101.

History: En. Sec. 1, Ch. 213, L. 2005; amd. Sec. 29, Ch. 157, L. 2023.

33-23-311. Repealed. Sec. 73, Ch. 227, L. 2001.

History: (1)En. 40-2827 by Sec. 1, Ch. 212, L. 1977; Sec. 40-2827, R.C.M. 1947; (2)En. 40-2828 by Sec 2, Ch. 212, L. 1977; Sec. 40-2828, R.C.M. 1947; (3)En. 40-2829 by Sec. 3, Ch. 212, L. 1977; Sec. 40-2829, R.C.M. 1947; R.C.M. 1947, 40-2827, 40-2828, 40-2829.

33-23-312. Cancellation or nonrenewal of all policies. Any insurer insuring a person described in 33-23-302 who elects to cancel or not renew all policies for all persons identified in 33-23-302 shall provide notice of the decision to cancel or not renew coverage to all affected persons described in 33-23-302 at least 120 days prior to cancellation or nonrenewal.

History: En. Sec. 7, Ch. 339, L. 2003.

Part 4
Homes

Part Cross-References

Credit insurance on real property — borrower allowed choice of insurers, 33-18-501.

Discrimination in insurance and retirement plans, 49-2-309.

33-23-401. Written notice required for cancellation or nonrenewal of insurance policies on homes. An insurer may not cancel or refuse to renew any policy insuring private residences, including but not limited to fire, home owner, theft, or liability insurance on any home occupied by the insured as a domicile, without first giving to the insured 45 days' notice in writing, including in the notice a statement of the specific reason or reasons for canceling or not renewing the policy, except that a policy may be canceled for nonpayment of premiums, in which case, the notice to the insured may not be less than 20 days.

History: En. Secs. 1, 2, Ch. 374, L. 1971; amd. Secs. 1, 2, Ch. 82, L. 1975; R.C.M. 1947, 40-4415, 40-4416; amd. Sec. 8, Ch. 339, L. 2003; amd. Sec. 3, Ch. 263, L. 2005; amd. Sec. 30, Ch. 396, L. 2017.

Cross-References

Home owner insurance not affected by day-care operations, 33-15-1111.

Part 5
Medical Malpractice Insurance Joint Underwriting Association (Repealed)

33-23-501. Repealed. Sec. 2, Ch. 21, L. 2021.

History: En. Sec. 1, Ch. 475, L. 2005.

33-23-502. Repealed. Sec. 2, Ch. 21, L. 2021.

History: En. Sec. 2, Ch. 475, L. 2005.

33-23-503. Repealed. Sec. 2, Ch. 21, L. 2021.

History: En. Sec. 3, Ch. 475, L. 2005.

33-23-504 through 33-23-506 reserved.

33-23-507. Repealed. Sec. 2, Ch. 21, L. 2021.

History: En. Sec. 4, Ch. 475, L. 2005.

33-23-508. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 5, Ch. 475, L. 2005.

33-23-509. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 6, Ch. 475, L. 2005.

33-23-510. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 7, Ch. 475, L. 2005.

33-23-511. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 8, Ch. 475, L. 2005.

33-23-512. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 9, Ch. 475, L. 2005.

33-23-513. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 10, Ch. 475, L. 2005.

33-23-514. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 11, Ch. 475, L. 2005.

33-23-515. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 12, Ch. 475, L. 2005.

33-23-516 through 33-23-518 reserved.

33-23-519. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 13, Ch. 475, L. 2005.

33-23-520. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 14, Ch. 475, L. 2005.

33-23-521. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 15, Ch. 475, L. 2005.

33-23-522. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 16, Ch. 475, L. 2005.

33-23-523. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 17, Ch. 475, L. 2005.

33-23-524. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 18, Ch. 475, L. 2005.

33-23-525. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 19, Ch. 475, L. 2005.

33-23-526. Repealed. Sec. 2, Ch. 21, L. 2021.
History: En. Sec. 20, Ch. 475, L. 2005.

CHAPTER 24
PROPERTY INSURANCE

Part 1 — General Provisions

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33-24-102. Insuring improvements — insurance equal to true value.
33-24-103. Specific valuation — loss equal to insured value.
33-24-104. Tax lien on insured property destroyed by fire.
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33-24-401. Short title.
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33-24-407. Insurance producer training.
33-24-408. Rulemaking.
33-24-409. Violations.

Chapter Cross-References

Denial of insurance — credit report — consumer's rights, 31-3-131.
Consumer loans — insurance as security, 32-5-306.
Property insurance — definition, 33-1-210.
Premium changes and cancellation of property insurance, Title 33, ch. 15, part 11.
Credit insurance on real or personal property — borrower allowed choice of insurers, 33-18-501.
Destruction of property to defraud insurer — crime, 45-6-101.
Discrimination in insurance and retirement plans, 49-2-309.
Fire losses — information available to state agencies, 50-63-401.
Report of suspicious fires, 50-63-402.

Part 1
General Provisions

33-24-101. Measure of the indemnity — rescission for fraud. If there is no valuation in the policy and unless a basis more favorable to the insured is provided for in the policy, the measure of indemnity in an insurance against fire is the expense, at the time that the loss is payable, of replacing the thing lost or injured, in the condition in which it was at the time of the injury; but a valuation, fraudulent in fact, entitles the insurer to rescind the contract.

History: En. Sec. 409, Ch. 286, L. 1959; R.C.M. 1947, 40-4301.

Cross-References

Fraud, 28-2-404 through 28-2-406.
Indemnity, Title 28, ch. 11, part 3.
Construction of policies, 33-15-316.

33-24-102. Insuring improvements — insurance equal to true value. Whenever any policy of insurance is written to insure any improvements upon real property in this state against loss or damage and the property insured is considered to be a total loss, without criminal fault on the part of the insured or the insured's assigns, the amount of insurance written in the policy must be taken conclusively to be the true value of the property insured and the true amount of loss and measure of damages. The payment of money as a premium for insurance must be prima facie evidence that the party paying the insurance premium is the owner of the property insured. However, any insurance company may assert fraud in obtaining the policy as a defense to a suit on the policy.

History: En. Sec. 410, Ch. 286, L. 1959; R.C.M. 1947, 40-4302; amd. Sec. 25, Ch. 303, L. 1981; amd. Sec. 1236, Ch. 56, L. 2009.

Cross-References

Construction of policies, 33-15-316.

33-24-103. Specific valuation — loss equal to insured value. (1) This section applies to policies, except motor vehicle insurance policies, that insure specific listed items of personal property against any loss or damage.

(2) If the insurer places specific valuations upon particular items of covered property and bases the premium charge on these valuations, then the insurer shall compute any total loss

or total damage to the property, when covered, at the stated valuation with no deductions or offsets except for the selected deductible in the policy.

History: En. 40-4303 by Sec. 1, Ch. 96, L. 1974; R.C.M. 1947, 40-4303; amd. Sec. 26, Ch. 303, L. 1981; amd. Sec. 37, Ch. 469, L. 2005.

33-24-104. Tax lien on insured property destroyed by fire. If taxes are due and unpaid on property covered by fire insurance and damaged or destroyed by fire, the government entity owed the taxes has a lien on fire insurance proceeds paid in relation to that property in the amount of the unpaid taxes.

History: En. Sec. 2, Ch. 447, L. 1989.

Cross-References

Tax liens and limitations, Title 15, ch. 16, part 4.

33-24-105. Property insurance policy — conformity with state statutes. A property insurance policy relative to a risk resident, located, or to be performed in this state must contain a provision or the equivalent thereto as follows:

"Conformity with Montana statutes. The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy."

History: En. Sec. 24, Ch. 798, L. 1991.

33-24-106 through 33-24-109 reserved.

33-24-110. Risk preventative measures for homeowners — premium reduction — fire, wind, and hail. (1) An insurer may provide a benefit or a premium reduction to a homeowner's insurance policyholder for preventative measures taken by the policyholder. Preventative measures include but are not limited to actions that reduce the risk of damage to property from fire, wind, or hail.

(a) Fire preventative measures include but are not limited to any of the following:

(i) using ignition-resistant, fire-resistive, or noncombustible building materials in construction, including noncombustible roofing or coating, exterior glazing for fire protection, and interior building materials designed to stop flame spread and prevent building collapse upon occupants and emergency service personnel;

(ii) maintaining an adequate outside water source;

(iii) providing annual confirmation, if requested by the insurer, that the insured has employed defensible space landscaping around the insured's structures;

(iv) keeping a border of at least 5 feet of nonflammable landscaping around the insured property;

(v) complying with any local, state, or federal fire prevention or community preparedness programs;

(vi) installing fire alarm or emergency alarm systems;

(vii) complying with the requirements of the International Wildland-Urban Interface Code if a building is located in a wildland-urban interface area; and

(viii) providing sufficient access to the property for firefighting equipment and authorized emergency vehicles as defined in 61-8-102.

(b) Wind and hail preventative measures include but are not limited to the following:

(i) using an industry-approved resistant roof shingle;

(ii) anchoring outdoor furniture;

(iii) pruning tree branches or otherwise providing landscaping that reduces potential damage to the insured property; and

(iv) installing protective coverings to avoid additional damage to the insured property.

(2) An insurer who provides a benefit or premium reduction as provided in this section must include the benefit or premium reduction in writing to the policyholder. A benefit or premium reduction provided by an insurer under this section does not constitute an illegal rebate under 33-18-210.

(3) For the purposes of this section, the following definitions apply:

(a) "Benefit" means a rebate, discount, abatement, credit, reduction of premium, or other advantage to the policyholder provided under the terms of a preventative measures agreement.

(b) "Policyholder" means a person who is the named insured in a homeowner's insurance policy.

History: En. Sec. 1, Ch. 105, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

Part 2

Portable Electronics Insurance Act

33-24-201. Short title. This part may be cited as the "Portable Electronics Insurance Act".

History: En. Sec. 1, Ch. 406, L. 2013.

33-24-202. Definitions. As used in this part, the following definitions apply:

(1) "Customer" means a person who purchases portable electronics or services related to the use of portable electronics.

(2) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(3) "Location" means any physical location in this state or any website, call center site, or similar location directed to residents of this state.

(4) "Portable electronics" means electronic devices that are portable in nature and their accessories.

(5) (a) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics that may provide coverage for portable electronics against loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. Portable electronics insurance also includes any agreement in which a person or any legal entity, in exchange for consideration paid, agrees to provide for the future repair, replacement, or provision of portable electronics.

(b) The term does not include:

(i) a service contract governed by Title 30, chapter 14, part 13;

(ii) a policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

(iii) a homeowner's, renter's, private passenger automobile, commercial, or similar policy.

(6) "Portable electronics transaction" means:

(a) the sale or lease of portable electronics by a vendor to a customer; or

(b) the sale of a service related to the use of portable electronics by a vendor to a customer.

(7) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by a licensed insurer to supervise the administration of a portable electronics insurance program.

(8) (a) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(b) The term does not include a cooperative organized and transacting business in this state pursuant to Title 35, chapter 18, its subsidiaries, or any other entity affiliated with the cooperative or its subsidiaries through common ownership.

History: En. Sec. 2, Ch. 406, L. 2013.

33-24-203. Licensure of vendors — rulemaking. (1) A vendor must hold a limited lines insurance producer license to sell or offer coverage under a policy of portable electronics insurance.

(2) A license issued under this part authorizes any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(3) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the commissioner and with 10 days' notice to the supervising entity, the registry must be open to inspection and examination by the commissioner during regular business hours of the supervising entity.

(4) A license issued under this part authorizes the licensee and its employees or authorized representatives to engage in those activities that are permitted in this part.

(5) The commissioner may adopt rules to implement the provisions of this part.

History: **En. Sec. 3, Ch. 406, L. 2013.**

33-24-204. Requirements for sale of portable electronics insurance. (1) At each location where portable electronics insurance is offered to customers, brochures or other written materials must be made available to a prospective customer that:

(a) disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

(b) state that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(c) summarize the material terms of the insurance coverage, including:

(i) the identity of the insurer;

(ii) the identity of the supervising entity;

(iii) the amount of any applicable deductible and how it is to be paid;

(iv) benefits of the coverage; and

(v) key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment;

(d) summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event that the customer fails to comply with any equipment return requirements; and

(e) state that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and that the person paying the premium shall receive a refund of any applicable unearned premium.

(2) The written materials required by this section are not subject to filing with or approval by the commissioner.

(3) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy, subject to 33-1-221 through 33-1-229, issued to a vendor of portable electronics for its enrolled customers.

(4) Eligibility and underwriting standards for customers electing to enroll in coverage must be established by the supervising entity for each portable electronics insurance program.

History: **En. Sec. 4, Ch. 406, L. 2013.**

33-24-205. Authority of vendors of portable electronics. (1) An employee or authorized representative of a vendor may sell or offer portable electronics insurance to a customer and is not subject to licensure as an insurance producer under this title provided that:

(a) the vendor obtains a limited lines insurance producer license to authorize its employees or authorized representatives to sell or offer portable electronics insurance;

(b) the insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the program, including development of a training program for employees and authorized representatives of the vendors. The training required by this subsection (1)(b) must comply with the following:

(i) the training must be delivered to employees and authorized representatives of a vendor who is directly engaged in the activity of selling or offering portable electronics insurance;

(ii) the training may be provided in electronic form. If the training is conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by licensed insurance producers or adjusters employed by the supervising entity; and

(iii) each employee and authorized representative individually must receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under 33-24-204;

(c) employees or authorized representatives of a vendor of portable electronics may not advertise, represent, or otherwise represent to the public that they are nonlimited lines licensed insurance producers.

(2) Employees or authorized representatives of a vendor of portable electronics may not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited lines insurance producer license that is incidental to their overall compensation.

(3) (a) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services must be separately itemized on the enrolled customer's bill.

(b) If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services.

(c) Vendors that are billing and collecting the charges are not required to maintain the funds in a segregated account if the vendor is authorized by the insurer to hold the funds in an alternative manner and remits the amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance are considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

History: En. Sec. 5, Ch. 406, L. 2013.

33-24-206. Application for vendor license — fees. (1) An applicant for a license under this part shall file with the commissioner an application on forms prescribed by the commissioner.

(2) The application must provide:

(a) the name, residence address, and other information required by the commissioner for an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this part, and if the vendor derives more than 50% of its revenue from the sale of portable electronics insurance, the information required by this subsection (2)(a) must be provided for all officers, directors, and shareholders of record having beneficial ownership of 10% or more of any class of securities registered under federal securities law; and

(b) the location of the applicant's home office.

(3) Any vendor engaging in portable electronics insurance transactions on or before August 1, 2013, shall apply for licensure within 90 days of the application being made available by the commissioner. Any applicant commencing operations after August 1, 2013, shall obtain a license prior to offering portable electronics insurance.

(4) Initial licenses issued under this part are valid for a period of 24 months.

(5) Each vendor of portable electronics licensed under this part shall pay to the commissioner a fee determined by the commissioner as follows:

(a) for a vendor that is engaged in portable electronics transactions at 10 or fewer locations in the state, the fee may not exceed $100 for an initial license or for each renewal; and

(b) for a vendor that is engaged in portable electronics transaction at more than 10 locations in the state, the fee may not exceed $1,000 for an initial license or $500 for each renewal.

History: En. Sec. 6, Ch. 406, L. 2013.

33-24-207. Suspension or revocation of vendor license. If a vendor of portable electronics or its employee or authorized representative violates any provision of this part, the commissioner may do any of the following after notice and the opportunity for a hearing:

(1) impose fines not to exceed $500 for each violation or $5,000 in the aggregate for violations;

(2) impose other penalties that the commissioner considers reasonable to carry out the purpose of this part, including:

(a) suspending the privilege of transacting portable electronics insurance under this part at specific business locations where violations have occurred; or

(b) suspending or revoking the ability of individual employees or authorized representatives to act under the license.

History: En. Sec. 7, Ch. 406, L. 2013.

33-24-208. Termination of portable electronics insurance. (1) Except as provided in subsections (3) through (5), an insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance upon providing the vendor policyholder and enrolled customers with at least 30 days' notice.

(2) If the insurer changes the terms and conditions of a policy of portable electronics insurance, the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating that a change in the terms and conditions has occurred and a summary of material changes.

(3) An insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the coverage.

(4) An insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy for nonpayment of premium with at least 10 days' notice.

(5) An insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy without prior notice:

(a) if the enrolled customer ceases to have an active service agreement with the vendor of portable electronics; or

(b) if an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. If the notice of exhaustion is not timely sent, the customer's enrollment must continue regardless of the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(6) When a portable electronics insurance policy is terminated by a vendor policyholder, the vendor policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice must be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(7) Any notice or correspondence with respect to a policy of portable electronics insurance required by this section or other applicable law must be in writing and sent within the required notice period. Notices and correspondence may be sent either by mail or by electronic means as set forth in this subsection. If the notice or correspondence is mailed, it must be sent to the vendor of portable electronics at the vendor's mailing address specified for the purpose and to an affected enrolled customer's last-known mailing address on file with the insurer. The insurer or vendor of portable electronics shall maintain proof of mailing in a form authorized or accepted by the United States postal service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it must be sent to the vendor of portable electronics at the vendor's electronic mail address specified for the purpose and to an affected enrolled customer's last-known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics. For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics is considered to be consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics shall maintain proof that the notice or correspondence was sent.

(8) Notices or correspondence required by this part or otherwise required by law may be sent on behalf of an insurer or vendor by the supervising entity appointed by the insurer.

History: En. Sec. 8, Ch. 406, L. 2013.

33-24-209. Portable electronics insurance claims. (1) An individual who collects claim information from or furnishes claim information to insureds or claimants and who conducts data entry, including entering data into an automated claims adjudication system, is exempt from licensure under this title if no more than 25 of these individuals are under the supervision of one licensed independent adjuster or licensed insurance producer who is exempt from licensure pursuant to 33-17-102(1)(b)(iii).

(2) For purposes of portable electronics insurance claims, residents of Canada may not be licensed as nonresident adjusters unless they have obtained a resident license in another state or designated another state as their home state.

(3) For purposes of this section, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of portable electronics insurance claims that:

(a) may be utilized only by a licensed independent adjuster, licensed insurance producer, or supervised individual operating pursuant to this section;

(b) must comply with all claims payment requirements of this title; and

(c) must be certified as compliant with this section by a licensed independent adjuster that is an officer of the entity that employs the individuals operating pursuant to this section.

History: **En. Sec. 9, Ch. 406, L. 2013.**

Part 3
Self-Storage Insurance Act

Part Cross-References

Self-Storage Facilities Act, Title 70, ch. 6, part 6.

33-24-301. Short title — purpose. This part may be cited as the "Self-Storage Insurance Act". The purpose of this act is to coordinate with the Self-Storage Facilities Act, Title 70, chapter 6, part 6, and allow for operators of the facilities to offer self-storage insurance to their renters.

History: **En. Sec. 1, Ch. 121, L. 2021.**

33-24-302. Definitions. As used in this part, the following definitions apply:

(1) "Authorized representative" means an individual authorized by an operator to sell or offer self-storage insurance coverage in accordance with this part.

(2) "Location" means any physical location in this state.

(3) (a) "Operator" means a business entity that is the owner, operator, lessor, or sublessor of a self-storage facility or an agent or another person authorized to manage the facility or to receive rent from a renter under a rental agreement.

(b) The term does not include a warehouse operator if the warehouse operator issues a warehouse receipt, bill of lading, or other document of title for the personal property stored. The operator may be a resident or nonresident of this state.

(4) "Personal property" means movable property not affixed to land.

(5) "Rental agreement" means a written agreement or lease that establishes or modifies the terms, conditions, or rules concerning the use and occupancy of a leased space at a self-storage facility.

(6) "Renter" means a person entitled to the use of a leased space at a self-storage facility under a rental agreement or the person's successors or assigns.

(7) "Self-storage facility" means real property consisting of individual storage spaces in which a renter customarily stores and removes personal property on a self-service basis.

(8) "Self-storage insurance" means insurance offered in connection with and incidental to the rental of a leased space at a self-storage facility and which provides coverage to renters for the loss of or damage to personal property occurring at the facility or when the property is in transit to or from the facility during the term of the rental agreement. Self-storage insurance coverage may be offered on a month-to-month or other periodic basis under an individual, commercial, or group policy.

(9) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by a licensed insurer to supervise the administration of a self-storage insurance program.

History: **En. Sec. 2, Ch. 121, L. 2021.**

33-24-303. Licensure of operators — rulemaking. (1) An operator must hold a limited lines insurance producer license in order to sell or offer self-storage insurance coverage. An operator is not required to hold a license solely to display and make available to renters and prospective renters brochures and other promotional materials created by or on behalf of an authorized insurer.

(2) A license issued under this part authorizes the operator and the employees and authorized representatives of the operator to sell and offer self-storage insurance coverage to renters at each location at which the operator conducts business.

(3) The supervising entity shall maintain a registry of the locations where the operator sells or offers self-storage insurance coverage in this state. On request by the commissioner and with 10 days' notice to the supervising entity, the registry must be open to inspection and examination by the commissioner during regular business hours of the supervising entity.

(4) A license issued under this part authorizes the operator and its employees and authorized representatives to engage in those activities that are permitted in this part.

(5) Operators and their employees and authorized representatives are exempt from all prelicensing examination and continuing education requirements.

(6) The commissioner may adopt rules to implement the provisions of this part.

History: **En. Sec. 3, Ch. 121, L. 2021.**

33-24-304. Brochures and materials explaining self-storage coverage. (1) At each location where self-storage insurance coverage is offered to renters, written or electronic brochures or materials must be made available to renters that:

(a) disclose that self-storage insurance may provide a duplication of coverage already provided by a renter's homeowner's insurance policy, renter's insurance policy, or other source of coverage;

(b) state that the enrollment by the renter in a self-storage insurance program offered by the operator is not required in order to rent a leased space at the self-storage facility;

(c) provide a copy of the actual self-storage insurance coverage, or summarize the material terms of the insurance coverage, including:

(i) the identity of the insurer;

(ii) the identity of the supervising entity, if different from the insurer;

(iii) the amount of any applicable deductible and how it is to be met;

(iv) benefits of the coverage; and

(v) key terms and conditions of the coverage;

(d) summarize the process for filing a claim; and

(e) state that a renter that purchases self-storage insurance coverage may cancel the coverage at any time and that the person paying the premium must receive a refund of any applicable unearned premium.

(2) The written or electronic brochures or materials required by this section are not subject to filing with or approval by the commissioner.

History: **En. Sec. 4, Ch. 121, L. 2021.**

33-24-305. Authority of operators. (1) An employee or authorized representative of an operator may sell and offer self-storage insurance coverage to a renter and is not subject to licensure as an insurance producer under this title provided that:

(a) the operator obtains a limited lines insurance producer license to authorize its employees or authorized representatives to sell and offer self-storage insurance coverage;

(b) the insurer issuing the self-storage insurance either directly supervises or appoints a supervising entity to supervise the administration of the program, including development of a training program for employees and authorized representatives of the operator. The training required by this subsection (1)(b) must comply with the following:

(i) the training must be delivered to employees and authorized representatives of an operator who are directly engaged in the activity of selling and offering self-storage insurance coverage;

(ii) if the training is provided in an electronic form, the supervising entity shall implement a supplemental education program regarding the self-storage insurance that is conducted and overseen by licensed insurance producers or adjusters; and

(iii) each employee and authorized representative who is directly engaged in the activity of selling and offering self-storage insurance must receive basic instruction about the self-storage insurance offered to renters and the disclosures required under 33-24-304(1); and

(c) employees and authorized representatives of an operator may not advertise, represent, or otherwise hold out to the public that they are nonlimited lines licensed insurance producers unless otherwise licensed.

(2) Employees or authorized representatives of an operator may not be compensated based primarily on the number of renters enrolled for self-storage insurance coverage but may receive

compensation for activities under the limited lines insurance producer license that is incidental to their overall compensation.

(3) (a) The charges for self-storage insurance coverage may be billed and collected by the operator and its employees and authorized representatives. If billed by the operator, the charges for self-storage insurance coverage must be separately itemized on the renter's bill.

(b) Operators that are billing and collecting the charges are not required to maintain the funds in a segregated account if the operator is authorized by the insurer or supervising entity to hold the funds in an alternative manner and remits the premiums to the insurer or supervising entity within 60 days of receipt. All premiums received by an operator from a renter for the sale of self-storage insurance are considered funds held by the operator in a fiduciary capacity for the benefit of the insurer. Operators may receive compensation for billing and collection services.

History: En. Sec. 5, Ch. 121, L. 2021.

33-24-306. Application for operator license — fees. (1) An applicant for a license under this part shall file with the commissioner an application on forms prescribed by the commissioner. The applicant may be a resident or nonresident of this state.

(2) (a) The application must provide:

(i) the name, residence address, and other information required by the commissioner for an authorized representative of the operator or supervising entity that is designated by the applicant as the person responsible for the operator's compliance with the requirements of this part; and

(ii) the location of the operator's home office.

(b) If the operator derives more than 50% of its revenue from the sale of self-storage insurance, the information required by subsection (2)(a) must be provided for all officers, directors, and shareholders of record having beneficial ownership of 10% or more of any class of securities registered under federal securities law.

(3) Initial licenses issued under this part are valid for a period of 24 months.

(4) Each operator licensed under this part shall pay to the commissioner a fee determined by the commissioner as follows:

(a) for an operator that sells self-storage insurance at 10 or fewer locations in the state, the fee may not exceed $100 for an initial license or for each renewal; and

(b) for an operator that sells self-storage insurance at more than 10 locations in the state, the fee may not exceed $250 for an initial license or $100 for each renewal.

History: En. Sec. 6, Ch. 121, L. 2021.

33-24-307. Suspension or revocation of operator license. If an operator or its employee or authorized representative violates any provision of this part, the commissioner may do any of the following after notice and the opportunity for a hearing:

(1) impose fines not to exceed $500 for each violation or $5,000 in the aggregate for violations; or

(2) impose other penalties that the commissioner considers reasonable to carry out the purpose of this part, including:

(a) suspending the privilege of transacting self-storage insurance under this part at specific business locations where violations have occurred; or

(b) suspending or revoking the ability of individual employees or authorized representatives to act under the license.

History: En. Sec. 7, Ch. 121, L. 2021.

Part 4
Montana Pet Insurance Act

33-24-401. Short title. This part may be cited as the "Montana Pet Insurance Act".

History: En. Sec. 1, Ch. 40, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

33-24-402. Scope and purpose. (1) The purpose of this part is to promote the public welfare by creating a comprehensive legal framework within which pet insurance may be sold in this state.

(2) The requirements of this part apply to pet insurance policies that are issued to a resident of this state and are sold, solicited, negotiated, or offered in this state, and policies or certificates that are delivered or issued for delivery in this state.

(3) All other applicable provisions of Title 33 continue to apply to pet insurance, except that specific provisions of this part supersede any general provisions of law that would otherwise be applicable to pet insurance.

History: **En. Sec. 2, Ch. 40, L. 2025.**

Compiler's Comments
Effective Date: This section is effective October 1, 2025.

33-24-403. Definitions. (1) If a pet insurer uses any of the terms in this part in a policy of pet insurance, the pet insurer shall use the definition of each of those terms as set forth in this section and include the definition of the terms in the policy.

(2) Nothing in this part prohibits or limits the types of exclusions pet insurers may use in their policies or require pet insurers to have any of the limitations or exclusions defined below.

(3) As used in this part, the following definitions apply:

(a) "Chronic condition" means a condition that can be treated or managed, but not cured.

(b) "Congenital anomaly or disorder" means a condition that is present from birth, whether inherited or caused by the environment, which may cause or contribute to illness or disease.

(c) "Hereditary disorder" means an abnormality that is genetically transmitted from parent to offspring and may cause illness or disease.

(d) "Orthopedic" refers to conditions affecting the bones, skeletal muscle, cartilage, tendons, ligaments, and joints. It includes but is not limited to elbow dysplasia, hip dysplasia, intervertebral disc degeneration, patellar luxation, and ruptured cranial cruciate ligaments. It does not include cancers or metabolic, hemopoietic, or autoimmune diseases.

(e) "Pet" means any domesticated animal normally maintained in or near the household of its owner. It does not include livestock as defined in 81-8-213 kept for any commercial purpose.

(f) "Pet insurance" means a property insurance policy that provides coverage for accidents and illnesses of pets.

(g) (i) "Preexisting condition" means any condition for which any of the following are true prior to the effective date of a pet insurance policy or during any waiting period:

(A) a veterinarian provided medical advice;

(B) the pet received previous treatment; or

(C) based on information from verifiable sources, the pet had signs or symptoms directly related to the condition for which a claim is being made.

(ii) A condition for which coverage is afforded on a policy may not be considered a preexisting condition on any renewal of the policy.

(h) "Renewal" means to issue and deliver at the end of an insurance policy period a policy that supersedes a policy previously issued and delivered by the same pet insurer or affiliated pet insurer and that provides types and limits of coverage substantially similar to those contained in the policy being superseded.

(i) "Veterinarian" means an individual who holds a valid license to practice veterinary medicine under 37-18-305 or a similar state law in the jurisdiction in which the veterinarian practices.

(j) "Veterinary expenses" means the costs associated with medical advice, diagnosis, care, or treatment provided by a veterinarian, including but not limited to the cost of drugs prescribed by a veterinarian.

(k) "Waiting period" means the period of time specified in a pet insurance policy that is required to transpire before some or all of the coverage in the policy can begin. Waiting periods may not be applied to renewals of existing coverage.

(l) "Wellness program" means a subscription or reimbursement-based program that is separate from an insurance policy and that provides goods and services to promote the general health, safety, or wellbeing of the pet. A wellness program otherwise meeting the definition of insurance set forth in 33-1-201 is still subject to Title 33. This definition is not intended to classify a contract directly between a service provider and a pet owner that only involves the two parties as being insurance unless other indicia of an insurance contract also exist.

History: **En. Sec. 3, Ch. 40, L. 2025.**

Compiler's Comments
Effective Date: This section is effective October 1, 2025.

33-24-404. Disclosures. (1) Before completing the sale of a pet insurance policy, a pet insurer transacting in pet insurance shall disclose the following to consumers:

(a) if the policy excludes coverage due to any of the following:

(i) a preexisting condition;

(ii) a hereditary disorder;

(iii) a congenital anomaly or disorder; or

(iv) a chronic condition;

(b) if the policy includes any other exclusions, the following statement: "Other exclusions may apply. Please refer to the exclusions section of the policy for more information."

(c) any policy provision that limits coverage through a waiting period or affiliation period, a deductible, coinsurance, or an annual or lifetime policy limit;

(d) whether the pet insurer reduces coverage or increases premiums based on the insured's claim history, the age of the covered pet, or a change in the geographic location of the insured; and

(e) if the underwriting company differs from the brand name used to market and sell the product.

(2) (a) As provided in this subsection (2), an insured has the right to examine and return the policy.

(b) Unless the insured has filed a claim under the pet insurance policy, pet insurance applicants have the right to examine and return the policy, certificate, or rider to the company or an insurance producer of the company within 15 days of its receipt and to have the premium refunded if, after examination of the policy, certificate, or rider, the applicant is not satisfied for any reason.

(c) Pet insurance policies, certificates, and riders must have a notice prominently printed on the first page or attached to the first page including specific instructions to accomplish a return. The following free look statement or language that is substantially similar must be included:

"You have 15 days from the day you receive this policy, certificate, or rider to review it and return it to the company if you decide not to keep it. You do not have to tell the company why you are returning it. If you decide not to keep it, simply return it to the company at its administrative office or to the agent/insurance producer that you bought it from, so long as you have not filed a claim. You must return it within 15 days of the day you first received it. The company will refund the full amount of any premium paid within 30 days after it receives the returned policy, certificate, or rider. The premium refund will be sent directly to the person who paid it. The policy, certificate, or rider will be void as if it had never been issued."

(3) A pet insurer shall clearly disclose a summary description of the basis or formula on which the pet insurer determines claim payments under a pet insurance policy within the policy, prior to policy issuance.

(4) A pet insurer that uses a benefit schedule to determine claim payment under a pet insurance policy shall clearly disclose the applicable benefit schedule in the policy.

(5) A pet insurer that determines claim payments under a pet insurance policy based on usual and customary fees, or any other reimbursement limitation based on prevailing veterinary service provider charges, shall include a usual and customary fee limitation provision in the policy that clearly describes the pet insurer's basis for determining usual and customary fees and how that basis is applied in calculating claim payments.

(6) If a medical examination by a licensed veterinarian is required to effectuate coverage, the pet insurer shall clearly and conspicuously disclose the required aspects of the examination prior to purchase and disclose that examination documentation may result in a preexisting condition exclusion.

(7) Waiting periods and the requirements applicable to them must be clearly and prominently disclosed to consumers prior to the policy purchase.

(8) The pet insurer shall include a summary of all policy provisions required in subsections (1) through (7) in a separate document titled "Insurer Disclosure of Important Policy Provisions".

(9) In connection with the issuance of a new pet insurance policy, the pet insurer shall provide the consumer with a copy of the "Insurer Disclosure of Important Policy Provisions" document required pursuant to subsection (8) in at least 12-point type when it delivers the policy.

(10) (a) At the time a pet insurance policy is issued or delivered to a policyholder, the pet insurer shall include a written disclosure with the following information, printed in at least 12-point boldface type:

(i) the commissioner's mailing address, toll-free telephone number, and website address; and

(ii) the address and customer service telephone number of the pet insurer and the agent or broker of record, if the policy was issued or delivered by an agent or broker.

(b) The disclosures required in this section are in addition to any other disclosure requirements required by law or rules promulgated by the commissioner.

History: En. Sec. 4, Ch. 40, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

33-24-405. Policy conditions. (1) A pet insurer may issue policies that exclude coverage on the basis of one or more preexisting conditions with appropriate disclosure to the consumer. The pet insurer has the burden of proving that the preexisting condition exclusion applies to the condition for which a claim is being made.

(2) (a) A pet insurer may issue policies that impose waiting periods upon effectuation of the policy that do not exceed 30 days for illnesses or orthopedic conditions not resulting from an accident. Waiting periods for accidents are prohibited.

(b) (i) A pet insurer utilizing a waiting period permitted in this subsection (2) shall include a provision in its contract that allows the waiting period to be waived upon completion of a medical examination. Pet insurers may require the examination to be conducted by a licensed veterinarian after the purchase of the policy.

(ii) A medical examination under this subsection (2)(b) must be paid for by the policyholder unless the policy specifies that the pet insurer will pay for the examination.

(iii) A pet insurer may specify elements to be included as part of the examination and require documentation of the included elements, provided the specifications do not unreasonably restrict a consumer's ability to waive the waiting periods in this subsection (2).

(c) Waiting periods, and the requirements applicable to them, must be clearly and prominently disclosed to consumers prior to the policy purchase.

(3) A pet insurer may not require a veterinary examination of the covered pet for the insured to have the insured's policy renewed.

(4) If a pet insurer includes any prescriptive, wellness, or noninsurance benefits in the policy form, then it is made part of the policy contract and must follow all applicable laws and regulations in Title 33.

(5) An insured's eligibility to purchase a pet insurance policy may not be based on participation, or lack of participation, in a separate wellness program.

History: En. Sec. 5, Ch. 40, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

33-24-406. Sales practices for wellness programs. (1) A pet insurer and producer selling pet insurance may not:

(a) market a wellness program as pet insurance; or

(b) market a wellness program during the sale, solicitation, or negotiation of pet insurance.

(2) If a wellness program is sold by a pet insurer and producer:

(a) the purchase of the wellness program may not be a requirement to the purchase of pet insurance;

(b) the costs of the wellness program must be separate and identifiable from any pet insurance policy;

(c) the terms and conditions for the wellness program must be separate from any pet insurance policy;

(d) the products or coverages available through the wellness program may not duplicate products or coverages available through the pet insurance policy;

(e) the advertising of the wellness program may not be misleading and must be in accordance with this subsection (2); and

(f) the pet insurer and producer shall clearly disclose the following to consumers, printed in at least 12-point boldface type:

(i) that wellness programs are not insurance;

(ii) the address and customer service telephone number of the pet insurer and producer or broker of record, if the policy was issued or delivered by an agent or broker; and

(iii) the mailing address, telephone number, and website address for the commissioner's office.

(3) Coverages included in the pet insurance policy contract described as "wellness" benefits are insurance.

History: En. Sec. 6, Ch. 40, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

33-24-407. Insurance producer training. (1) An insurance producer may not sell, solicit, or negotiate a pet insurance product until after the producer is appropriately licensed and has completed the required training identified in subsection (4), and completes the training once within every 24-month period after the initial training.

(2) The training requirements of this section may be approved as continuing education courses under Title 33, chapter 17, part 12.

(3) An insurer covered by this part shall ensure that its producers are trained under subsection (4) and that its producers have been appropriately trained on the coverages and conditions of its pet insurance products.

(4) The training required under this subsection must include 2 total hours of training covering the following topics:

(a) preexisting conditions and waiting periods;

(b) the differences between pet insurance and noninsurance wellness programs;

(c) hereditary disorders, congenital anomalies or disorders, and chronic conditions and how pet insurance policies interact with those conditions or disorders; and

(d) rating, underwriting, renewal, and other related administrative topics.

(5) The satisfaction of the training requirements of another state that are substantially similar to the provisions of subsection (4) satisfy these training requirements.

(6) (a) An insurer subject to this section shall obtain verification that an insurance producer acting on the insurer's behalf receives the training required by this section before the insurance producer is permitted to sell, solicit, or negotiate the insurer's pet insurance products.

(b) The insurer shall maintain records subject to this state's record retention requirements and make the verification of the insurance producer's compliance with training requirements available to the commissioner upon request.

History: En. Sec. 7, Ch. 40, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

33-24-408. Rulemaking. The commissioner may adopt rules implementing this part.

History: En. Sec. 8, Ch. 40, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

33-24-409. Violations. Violations of this part are subject to penalties and remedies set forth in 33-1-317, 33-1-318, and Title 33, chapter 18.

History: En. Sec. 9, Ch. 40, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

CHAPTER 25

MONTANA TITLE INSURANCE ACT

Part 1 — General Provisions

33-25-101. Renumbered 33-25-211.
33-25-102. Renumbered 33-25-212.
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Part 2 — Powers and Duties of Title Insurers

33-25-201. Escrow, closing, or settlement services — title indemnification — maintenance of accounts — maintenance of nominal or short-term accounts — rules.
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33-25-214. Underwriting standards — record retention.
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Part 3 — Regulation by Commissioner of Insurance

33-25-301. Refusal, suspension, or revocation of title insurance producer's license.
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Part 4 — Prohibited Practices — Penalties

33-25-401. Prohibited practices — referrals — splitting charges — exemptions.
33-25-402. Prohibited practices — penalties — treble damages, court costs, and attorney fees — injunction.
33-25-403. Prohibited practices — producer and associates — prohibition of favored insurance producer or insurer.

Chapter Cross-References

Title plant owned by title insurer or title insurance producer — exemption from taxation, 15-6-201.
Title insurance — definition, 33-1-212.
Commissioner to approve policy forms, Title 33, ch. 1, part 5.
Combinations of insuring powers, 33-2-108.
Examination of applicant for title insurance producer's license, 33-17-212.
Discrimination in insurance and retirement plans, 49-2-309.
Authority to be trustee — trust indentures, 71-1-306.

Part 1
General Provisions

33-25-101. Renumbered 33-25-211. Code Commissioner, 1985.

33-25-102. Renumbered 33-25-212. Code Commissioner, 1985.

33-25-103. Repealed. Sec. 22, Ch. 519, L. 1985.

History: En. Sec. 415, Ch. 286, L. 1959; R.C.M. 1947, 40-4601; amd. Sec. 2, Ch. 84, L. 1983.

33-25-104. Short title. This chapter may be cited as the "Montana Title Insurance Act".

History: En. Sec. 1, Ch. 519, L. 1985.

33-25-105. Definitions. As used in this chapter, the following definitions apply:

(1) "Abstract" means a written representation, provided pursuant to a contract and expected to be relied upon by the person who has contracted for the receipt of that representation, listing all recorded conveyances, instruments, or documents which, under the laws of this state, impart constructive notice regarding the chain of title to real property described in the abstract. Abstract includes "abstract of title".

(2) "Applicant" means a person, whether or not a prospective insured, who applies to a title insurer or title insurance producer for a title insurance policy, but does not include a title insurance producer.

(3) "Approved attorney" means an attorney authorized to practice law in this state, except an agent or employee of a title insurer, whose certification as to the status of the title to real property a title insurer is willing to accept as the basis for issuance of a title insurance policy.

(4) "Associate" means a:

(a) corporation, partnership, or other business entity organized for profit, of which a producer of title business is a director, officer, partner, employee, or owner of 5% or more of its equity or capital;

(b) franchisor or franchisee of a producer of title business;

(c) spouse, parent, or child of a producer of title business;

(d) corporation, partnership, or other business entity that controls, is controlled by, or is under common control with a producer of title business; or

(e) person with whom a producer of title business or an associate has an agreement, arrangement, understanding, or course of conduct having the purpose or substantial effect of evading the provisions of this title.

(5) "Controlled business" means that portion of the business of title insurance in this state of a title insurer or title insurance producer that is referred to it by a producer or associate having a financial interest in the title insurer or title insurance producer.

(6) "Financial interest" means a legal or beneficial interest that entitles the holder, directly or indirectly, to 1% or more of the net profits or net worth of the entity in which the interest is held.

(7) "Preliminary report" means an offer to issue a title insurance policy subject to any exceptions stated in the report or other matters that may be incorporated by reference therein. Preliminary report includes a commitment or binder.

(8) "Producer of title business" or "producer" means a person, corporation, partnership, or other business entity, including an officer, director, or owner of 5% or more of the equity or capital thereof, engaged in this state in the trade, business, occupation, or profession of:

(a) buying or selling interests in real property;

(b) making loans secured by interests in real property; or

(c) acting as broker, insurance producer, or representative of a person described in subsection (8)(a) or (8)(b).

(9) "Rate" means fees for:

(a) issuing a title insurance policy, including any service charge or fee for the issuance;

(b) abstracting, searching, and examining title to real property when prepared or issued in contemplation of or in conjunction with the issuance of a title insurance policy; and

(c) preparing or issuing preliminary reports, commitments, binders, or similar products prepared or issued in contemplation of or in conjunction with the issuance of a title insurance policy.

(10) "Refer" means to direct, cause to be directed, or exercise an influence over the direction of title insurance business, whether or not the consent or approval of another person is sought or obtained with respect to the referral.

(11) "Title guarantee" means a contract by which, subject to its stated terms and conditions, a title insurer guarantees the assured against loss sustained by reason of the incorrectness of assurances set forth in the title guarantee with respect to the stated property. The term includes a trustee's sale guarantee, litigation guarantee, lot book guarantee, subdivision guarantee, recorded documents guarantee, or other form of guarantee filed with and approved by the commissioner.

(12) "Title insurance business" means:

(a) issuing or offering to issue a title insurance policy as an insurer;

(b) transacting or proposing to transact any of the following as a title insurer or title insurance producer, in contemplation of or in conjunction with the issuance of a title insurance policy:

(i) soliciting or negotiating the issuance of a title insurance policy;

(ii) guaranteeing, warranting, or otherwise insuring the correctness of title searches;

(iii) handling escrows, settlements, or closings;

(iv) executing title insurance policies, reports, commitments, binders, and endorsements;

(v) effecting contracts of reinsurance; or

(vi) abstracting, searching, or examining titles;

(c) transacting, as a title insurer or insurance producer, matters subsequent to the issuance of a title insurance policy and arising out of the policy; or

(d) doing or proposing to do business that, in substance, is equivalent to any of the activities described in subsections (12)(a) through (12)(c) in a manner designed to evade the provisions of this title.

(13) "Title insurance policy" means a contract by which, subject to its stated terms and conditions, a title insurer insures or indemnifies the insured against loss or damage sustained by reason of:

(a) defects in or liens or encumbrances on the title to the stated property;

(b) unmarketability of the title to the stated property; or

(c) invalidity or unenforceability of liens or encumbrances on the stated property.

(14) (a) "Title insurance producer" means a person who holds a valid title insurance producer's license and is authorized in writing by a title insurer to:

(i) solicit title insurance business;

(ii) collect rates;

(iii) determine insurability in accordance with underwriting rules and standards of the insurer; or

(iv) issue policies of the title insurer.

(b) Title insurance producer does not include an approved attorney.

(15) "Title insurer" means an insurer formed and authorized under the laws of this state to transact the business of title insurance in this state or a foreign or alien insurer so authorized.

(16) "Title plant" means a set of privately maintained records in which entries have been made of documents imparting constructive notice, under the law, of matters affecting title to real property, an interest therein, or an encumbrance thereon, that have been filed or recorded in the jurisdiction for which the title plant is maintained and from which the ownership of real property within the jurisdiction can be ascertained and liens, encumbrances, defects, and clouds on title to the real property can be determined.

History: **En. Sec. 2, Ch. 519, L. 1985; amd. Secs. 1, 3, Ch. 713, L. 1989; amd. Sec. 30, Ch. 157, L. 2023.**

Cross-References

Title plant owned by title insurer or title insurance producer — exemption from taxation, 15-6-201.
Title insurance — definition, 33-1-212.

33-25-106. Application. (1) This chapter applies to all title insurers, title insurance rating organizations, title insurance producers, applicants for title insurance, title insurance policyholders, and all other persons engaged in title insurance business in this state.

(2) This chapter does not authorize the practice of law by a person who is not licensed to practice law in this state, and this chapter does not authorize the commissioner to regulate the practice of law.

History: **En. Sec. 3, Ch. 519, L. 1985; amd. Sec. 3, Ch. 713, L. 1989.**

33-25-107 through 33-25-110 reserved.

33-25-111. Abstracts of title distinguished from title insurance policy and preliminary report. (1) A title insurance policy is not an abstract of title or representation as to the condition of title to the stated property.

(2) A preliminary report is not an abstract of title. The rights, duties, and liabilities applicable to the preparation and issuance of an abstract of title are not applicable to the issuance of a preliminary report. A preliminary report does not constitute a representation as to the condition of title to real property, but constitutes a statement of the terms and conditions upon which the issuer is willing to issue its title insurance policy.

History: **En. Sec. 4, Ch. 519, L. 1985.**

Part 2
Powers and Duties of Title Insurers

33-25-201. Escrow, closing, or settlement services — title indemnification — maintenance of accounts — maintenance of nominal or short-term accounts — rules. (1) A title insurer or title insurance producer may provide escrow, settlement, or closing services, or any combination of those services and may operate as an escrow, settlement, or closing agent subject to the provisions of subsections (2) through (9).

(2) A title insurer or title insurance producer shall:

(a) deposit funds accepted in connection with an escrow, settlement, closing, or title indemnification in a separate fiduciary trust account in a bank or other financial institution insured by an agency of the federal government and segregate the funds by escrow, settlement, closing, or title indemnification in its records. The funds are the property of the person entitled to the funds under the terms of the escrow, settlement, closing, or title indemnification and are not subject to debts of the title insurer or title insurance producer. A title insurer or title insurance producer may use the funds only in accordance with the terms of the individual escrow, settlement, closing, or title indemnification under which the funds are accepted.

(b) except as provided in subsections (3) through (7), pay any interest received on funds deposited with it in connection with an escrow, settlement, closing, or title indemnification to the depositing person or as otherwise provided by the terms of the escrow, settlement, closing, or title indemnification;

(c) maintain separate records of all receipts and disbursements of escrow, settlement, closing, or title indemnification funds; and

(d) comply with rules adopted by the commissioner pertaining to escrow, settlement, closing, or title indemnification transactions.

(3) In the absence of written instructions to the contrary, a title insurer or title insurance producer may maintain a pooled, interest-bearing, depository account for deposit of trust funds that are nominal in amount or expected to be held for a short period of time. The account must comply with the following provisions:

(a) The account may include only trust funds that are nominal in amount or that are expected to be held for a short period of time.

(b) Interest from the account may not be made available to the title insurer or title insurance producer.

(c) The determination of whether trust funds are nominal in amount or to be held for a short period of time is to be determined by each title insurer or title insurance producer.

(d) Notification to parties whose funds are nominal in amount or to be held for a short period of time is not required.

(4) An interest-bearing account established pursuant to subsection (3) may be established with any financial institution that is authorized by federal or state law to do business in the state in which the title insurer's or title insurance producer's office is situated and that is a member of the federal deposit insurance corporation. Funds deposited in the accounts must be subject to withdrawal upon request and without delay.

(5) (a) The Montana land title association shall establish the Montana land title foundation for the administration of the funds generated by the interest on trust accounts program for the following purposes:

(i) to support Montana nonprofit charitable organizations;

(ii) to provide continuing education programs for licensed title insurance agents; and

(iii) to promote knowledge and awareness of the real estate and title insurance industries.

(b) The foundation shall establish bylaws for the administration of the foundation in accordance with subsections (5)(a)(i) through (5)(a)(iii).

(6) A title insurer or title insurance producer depositing funds in an account created pursuant to subsections (3) and (4) shall direct the depository institution to:

(a) at least quarterly, remit interest and dividends, less any service charges or fees, on the average monthly balance on the account or as otherwise computed in accordance with the institution's standard accounting practice for other depositors to the Montana land title association foundation; and

(b) transmit with each remittance to the foundation a statement showing the name of the title insurer or title insurance producer for whom the remittance is sent and the rate of interest applied.

(7) The Montana land title association foundation shall maintain records of each remittance and statement received from depository institutions for a period of at least 3 years and shall, upon request, promptly make available to a title insurer or title insurance producer the records and statements pertaining to the title insurer's or title insurance producer's account.

(8) All interest transmitted to the Montana land title association foundation must, after deductions for necessary and reasonable administrative expenses of the foundation for operating the interest on trust accounts program, be distributed by the foundation for the purposes set forth in subsections (5)(a)(i) through (5)(a)(iii) in whatever proportion the foundation determines is appropriate.

(9) A title insurance producer shall keep books of account, records, and vouchers pertaining to any escrow, closing, settlement, or title indemnification business transacted, in a manner that allows the commissioner or the commissioner's authorized representative to readily ascertain, under the authority of 33-1-402, whether the title insurance producer has complied with all applicable provisions of this title.

History: En. Sec. 7, Ch. 519, L. 1985; amd. Secs. 1, 3, Ch. 713, L. 1989; amd. Sec. 1, Ch. 250, L. 1995.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-25-202. Sharing of rate proceeds. Title insurers and insurance producers may share rate proceeds between or among themselves in any combination and may accept commissions as provided in 33-17-1103, unless the sharing of rate proceeds is an unlawful rebate or inducement under this title or is a payment of a forwarding fee or finders fee.

History: En. Sec. 11, Ch. 519, L. 1985; amd. Sec. 61, Ch. 713, L. 1989.

33-25-203 through 33-25-210 reserved.

33-25-211. Guaranty fund — investments. (1) A title insurer shall establish and maintain the guaranty fund required under 33-2-517 and may invest in necessary plant and equipment and in other investments as authorized under this section.

(2) In addition to other investments eligible under this part, a title insurer may invest and have invested an amount not exceeding 50% of its paid-in capital stock in its title plant, in equipment, and with the commissioner's consent, in stock of abstract companies and of title insurance producers.

(3) Investments authorized by this section may not be credited against the insurer's required guaranty fund or unearned premium reserve provided for under 33-2-517.

(4) A title plant and equipment may not be allowed as an asset in any determination of the insurer's financial condition at a value greater than actual cost.

History: En. Sec. 417, Ch. 286, L. 1959; R.C.M. 1947, 40-4603; Sec. 33-25-101, MCA 1983; redes. 33-25-211 by Code Commissioner, 1985; amd. Sec. 47, Ch. 304, L. 1999.

33-25-212. Rates filed with commissioner. (1) A title insurer shall file with the commissioner a complete schedule of rates to be charged by it for title insurance as to property located in this state. The rates must be all-inclusive of the total charge for insurance as specified in the policy and must be accompanied by supporting data.

(2) A rate may not be excessive, inadequate, or unreasonably discriminatory.

(3) A title insurer may not quote or charge any rate for title insurance other than the applicable rate previously filed by it with the commissioner.

History: En. Sec. 416, Ch. 286, L. 1959; R.C.M. 1947, 40-4602; amd. Sec. 27, Ch. 303, L. 1981; Sec. 33-25-102, MCA 1983; redes. 33-25-212 by Code Commissioner, 1985; amd. Sec. 20, Ch. 399, L. 2007.

Cross-References

Hearings by Commissioner, 33-1-701.

33-25-213. Limitations on authority. (1) An insurer that transacts or is licensed to transact a class or kind of insurance other than title insurance is not eligible for the issuance or renewal of a license to transact the business of title insurance in this state and may not transact, underwrite, or issue title insurance. An insurer authorized to transact any combination of kinds of insurance, including title insurance, under an existing certificate of authority may continue to do so until the certificate of authority is renewed effective June 1, 1986.

(2) A title insurer may not engage in the business of guaranteeing payment of the principal or interest of bonds or mortgages.

(3) A title insurer may not engage in the business of guaranteeing the obligations of other persons, except its title insurance producers or approved attorneys in the normal course of its business.

History: En. Sec. 5, Ch. 519, L. 1985; amd. Sec. 3, Ch. 713, L. 1989.

Cross-References

Combinations of insuring powers, 33-2-108.

33-25-214. Underwriting standards — record retention. (1) A title insurer may not issue a title insurance policy unless it, its title insurance producer, or an approved attorney has conducted a reasonable search and examination of the title and made a determination of insurability of title in accordance with sound underwriting practices. The title insurer or title insurance producer shall preserve and retain in its files evidence of the examination of title and determination of insurability. The title insurer or title insurance producer may keep original evidence or may establish in the regular course of business a system of recording, copying, or reproducing evidence by any process that accurately and legibly reproduces, or forms a durable medium for reproducing, the contents of the original.

(2) Subsection (1) does not apply to:

(a) a title insurer assuming liability through a contract of reinsurance; or

(b) a title insurer acting as coinsurer if one of the other coinsuring title insurers has complied with subsection (1).

(3) Except as allowed by rules adopted by the commissioner, a title insurer or title insurance producer may not knowingly issue any title insurance product or commitment to insure unless all outstanding enforceable recorded liens or other interests against the property title to be insured are shown.

(4) An insurer issuing a policy in violation of this section is estopped, as a matter of law, to deny the validity of the policy as to any claim or demand of the insured arising under the policy.

History: En. Sec. 6, Ch. 519, L. 1985; amd. Sec. 62, Ch. 713, L. 1989; amd. Sec. 21, Ch. 399, L. 2007.

33-25-215. Report of claims. A title insurance producer must immediately report every loss claim to the title insurer that issued the policy against which the claim is presented.

History: En. Sec. 9, Ch. 519, L. 1985; amd. Sec. 3, Ch. 713, L. 1989.

33-25-216. Notice of issuance of mortgagee policy. (1) A title insurer or title insurance producer that issues a mortgagee's policy of title insurance on a loan made simultaneous to the purchase of all or part of the property securing the loan, when an owner's policy has not been ordered, shall inform the borrower in writing that the mortgagee's policy is to be issued, that the mortgagee's policy does not protect the borrower, and that the borrower may obtain an owner's title insurance policy for the borrower's protection. This notice must be provided, on a form prescribed by the commissioner, before issuance of the mortgagee's policy.

(2) If the borrower elects not to purchase an owner's title insurance policy, the title insurer or title insurance producer shall obtain from the borrower a statement in writing that the notice has been received and that the borrower waives the right to purchase an owner's title insurance policy. If the buyer refuses to provide the statement and waiver, the title insurer or title insurance producer shall indicate the refusal in the file. The statement and waiver must be on a form prescribed by the commissioner and must be retained by the title insurer or title insurance producer for at least 5 years after receipt.

History: En. Sec. 15, Ch. 519, L. 1985; amd. Sec. 3, Ch. 713, L. 1989; amd. Sec. 1237, Ch. 56, L. 2009.

Part 3
Regulation by Commissioner of Insurance

33-25-301. Refusal, suspension, or revocation of title insurance producer's license. (1) In addition to the causes provided in 33-17-1001, the commissioner may refuse to license an applicant or renew the license of a person as a title insurance producer or may suspend or revoke a title insurance producer's license or may fine a title insurance producer or applicant, after notice and opportunity for a hearing, if the commissioner finds that the license applicant or licensee has:

(a) made a material misstatement in an application for a title insurance producer license;

(b) commingled funds belonging to applicants, escrow participants, or others;

(c) intentionally misrepresented the terms of a title insurance policy to an applicant or policyholder or has misrepresented material facts to, concealed material facts from, or made false statements to a party to an escrow, settlement, or closing transaction;

(d) in conducting affairs as a title insurance producer, used coercive practices or demonstrated financial irresponsibility;

(e) aided, abetted, or assisted another person in violating the provisions of this title or a rule adopted by the commissioner.

(2) The commissioner may impose any other appropriate penalty provided for in this title.

(3) The commissioner may issue an order requiring restitution to injured parties and reimbursement of the commissioner's reasonable costs of bringing an administrative action pursuant to this section.

(4) The commissioner may refuse, suspend, or revoke the license of a person licensed as a title insurance producer for the actions described in subsection (1) committed by any individual designated in the license.

History: **En. Sec. 10, Ch. 519, L. 1985; amd. Sec. 63, Ch. 713, L. 1989; amd. Sec. 62, Ch. 227, L. 2001; amd. Sec. 31, Ch. 157, L. 2023.**

33-25-302. Disapproval of agency contracts. (1) The commissioner may disapprove a title agency contract between a title insurance producer and title insurer, upon appropriate notice to the parties to the contract, if the commissioner finds that the contract, together with all amendments and related documents:

(a) does not provide for adequate monitoring of the insurance producer's financial transactions; or

(b) provides for inadequate, unreasonable, or excessive amounts to be paid to or retained by the title insurance producer. Factors the commissioner may consider in this determination include but are not limited to the insurance producer's duties under the contract and the general level of amounts paid to or retained by other title insurance producers in the state performing or assuming comparable duties.

(2) A person may not act as a title insurance producer under an agency contract that has been disapproved by the commissioner.

History: **En. Sec. 8, Ch. 519, L. 1985; amd. Sec. 64, Ch. 713, L. 1989; amd. Sec. 1238, Ch. 56, L. 2009.**

Part 4
Prohibited Practices — Penalties

33-25-401. Prohibited practices — referrals — splitting charges — exemptions. (1) Except as provided in subsection (2), a person may not:

(a) give or accept a fee, rebate, or thing of value pursuant to an agreement or understanding that title insurance business will be referred to a title insurance producer; or

(b) give or accept a portion, split, or percentage of a charge made or received for title insurance business in connection with a transaction involving real property in this state, other than for services actually performed.

(2) (a) A person may pay a return on an investment, based on a percentage of an ownership interest in a title insurance agency, if:

(i) at or prior to the time of a referral, a disclosure of the existence of the arrangement is made to the person being referred and, in connection with the referral, the person is provided a written estimate of the charge or range of charges generally made by the title insurance producer to which the person is referred; and

(ii) the person is not required to use a particular insurance producer.

(b) The following arrangements are not a violation of subsection (2)(a)(ii):

(i) an arrangement that requires a buyer, borrower, or seller to pay for the services of an attorney, credit reporting agency, or real estate appraiser chosen by a lender to represent the lender's interest in a real estate transaction; or

(ii) an arrangement by which an attorney or law firm represents a client in a real estate transaction and issues or arranges for the issuance of a policy of title insurance in the transaction directly as insurance producer or through a separate corporate title insurance agency that may be established by that attorney or law firm and operated as an adjunct to the attorney's or firm's law practice.

(c) Failure to disclose a controlled business relationship is not a violation of subsection (2)(a)(i) if the failure was not intentional and resulted from a bona fide error, proven by a preponderance of the evidence.

(3) This section does not prohibit:

(a) the payment of a fee to an attorney for services actually rendered or by a title insurance producer for services actually performed in the issuance of a title insurance policy; or

(b) payment of a bona fide salary, compensation, or other payment for goods or facilities actually furnished or for services actually performed.

History: **En. Sec. 12, Ch. 519, L. 1985; amd. Sec. 65, Ch. 713, L. 1989; amd. Sec. 1239, Ch. 56, L. 2009.**

33-25-402. Prohibited practices — penalties — treble damages, court costs, and attorney fees — injunction. (1) A person found to have violated the provisions of 33-25-401 is jointly and severally liable to the person charged for the title insurance business involved in the violation for an amount equal to three times the amount of the charge paid for the business.

(2) In a civil action based on 33-25-401 and this section, the court may award to the prevailing party court costs plus reasonable attorney fees.

(3) The commissioner may bring a civil action to enjoin a violation of 33-25-401.

History: En. Sec. 13, Ch. 519, L. 1985.

Cross-References

Multiple defendants jointly and severally liable — right of contribution, 27-1-703.

Injunctions, Title 27, ch. 19.

33-25-403. Prohibited practices — producer and associates — prohibition of favored insurance producer or insurer. A producer or associate may not, directly or indirectly, require as a condition, agreement, or understanding of providing another person a loan, loan extension, credit, sale, property, contract, lease, or service that the other person obtain title insurance of any kind from a particular title insurer or title insurance producer. A title insurer or title insurance producer may not knowingly participate in a plan or transaction prohibited by this section.

History: En. Sec. 14, Ch. 519, L. 1985; amd. Sec. 66, Ch. 713, L. 1989.

CHAPTER 26
SURETYSHIP

Part 1 — Surety Insurance

33-26-101. Corporations as sureties.
33-26-102. Requisites of undertakings or bonds of individuals.
33-26-103. Rights of surety insurer to give bond.
33-26-104. Surety insurers as sole surety on official bonds — release.
33-26-105. Surety companies not permitted to furnish bonds where indemnity required.
33-26-106. Cost of surety bond to be allowed in account of officer.
33-26-107. Deposit of money in bank for safekeeping by executors and other fiduciaries on agreement with surety.
33-26-108. Rulemaking authority for surety insurers.
33-26-109. Surety bail bond premium — fees or interest.

Chapter Cross-References

Suretyship, Title 28, ch. 11, part 4.

Surety insurance — definition, 33-1-211.

Guaranteed arrest bond certificates — filing undertaking, 46-9-412.

Part 1
Surety Insurance

33-26-101. Corporations as sureties. (1) In all cases where an undertaking or bond, with any number of sureties, is authorized or required by any law of this state, any corporation with a paid-up capital of not less than $100,000, incorporated under the laws of this state for the purpose of making, guaranteeing, or becoming a surety upon bonds or undertakings required or authorized by law, may become and must be accepted as security or as a sole and sufficient security upon the undertaking or bond, and the corporate surety must be subject to all liabilities and entitled to all the rights of natural persons as sureties.

(2) Whenever the liabilities of any corporation described in subsection (1) exceed its assets, the state auditor shall require the deficiency to be paid up in 60 days, and if it is not paid up, then the state auditor shall issue a certificate showing the extent of the deficiency and shall publish the certificate once a week for 3 weeks in a daily paper published in the town or city in which the principal office of the corporation is located, and until the deficiency is paid up, the company may not be accepted as a surety on any undertaking or bond. In estimating the condition of a company, the state auditor shall allow as assets only assets that are allowed under existing laws at the time and shall charge as liabilities, in addition to 80% of the capital

stock, all outstanding indebtedness of the company and the premium reserved equal to 50% of the premiums charged by the company on all risks then in force.

History: **Ap. p. Sec. 1, p. 70, L. 1893; re-en. Sec. 1900, C. Civ. Proc. 1895; re-en. Sec. 7193, Rev. C. 1907; re-en. Sec. 9826, R.C.M. 1921; Cal. C. Civ. Proc. Sec. 1056; re-en. Sec. 9826, R.C.M. 1935; Sec. 93-8711, R.C.M. 1947; Ap. p. Sec. 2, p. 70, L. 1893; re-en. Sec. 1901, C. Civ. Proc. 1895; re-en. Sec. 7195, Rev. C. 1907; re-en. Sec. 9827, R.C.M. 1921; Cal. C. Civ. Proc. Sec. 1057; re-en. Sec. 9827, R.C.M. 1935; Sec. 93-8712, R.C.M. 1947; R.C.M. 1947, 93-8711, 93-8712(part); amd. Sec. 1240, Ch. 56, L. 2009.**

33-26-102. Requisites of undertakings or bonds of individuals. In all cases where an undertaking or bond or undertaking with sureties is authorized or required by any law of this state, the officer taking the same must, except in the case of corporations as mentioned in 33-26-101, require the sureties to accompany it with an affidavit that they are each responsible and are residents and householders or freeholders within the state and are each worth the sum specified in the undertaking or bond, over and above all their just debts and liabilities, exclusive of property exempt from execution. When the amount specified in the undertaking or bond exceeds $3,000 and there are more than two sureties thereon, they may state in their affidavits that they are severally worth amounts less than the amount specified in the undertaking or bond if the whole amount be equivalent to that of two sufficient sureties.

History: **Ap. p. Sec. 433, p. 131, Bannack Stat.; re-en. Sec. 593, p. 157, Cod. Stat. 1871; re-en. Sec. 523, p. 177, L. 1877; re-en. Sec. 523, 1st Div. Rev. Stat. 1879; re-en. Sec. 540, 1st Div. Comp. Stat. 1887; en. Sec. 1899, C. Civ. Proc. 1895; re-en. Sec. 7192, Rev. C. 1907; re-en. Sec. 9825, R.C.M. 1921; re-en. Sec. 9825, R.C.M. 1935; Sec. 93-8710, R.C.M. 1947; Ap. p. Sec. 2, p. 70, L. 1893; re-en. Sec. 1901, C. Civ. Proc. 1895; re-en. Sec. 7195, Rev. C. 1907; re-en. Sec. 9827, R.C.M. 1921; Cal. C. Civ. Proc. Sec. 1057; re-en. Sec. 9827, R.C.M. 1935; Sec. 93-8712, R.C.M. 1947; R.C.M. 1947, 93-8710, 93-8712(part).**

Cross-References

Property exempt from execution, Title 25, ch. 13, part 6.
Appeals from Justice's Court — applicability, 25-33-203.
Affidavit — definition, 26-1-1001.

33-26-103. Rights of surety insurer to give bond. A surety insurer authorized as such under this code shall have the power to become the surety on bonds and undertakings required by law, subject to all the rights and liabilities of private persons. This section shall not be deemed to limit in any way the powers, obligations, and liabilities of such insurers as provided for in other provisions of this code.

History: **En. Sec. 412, Ch. 286, L. 1959; R.C.M. 1947, 40-4501.**

Cross-References

Suretyship — general provisions, Title 28, ch. 11, part 4.
Certificate of authority required, 33-2-101.

33-26-104. Surety insurers as sole surety on official bonds — release. (1) Whenever any bond, undertaking, recognizance, or other obligation is by law or the charter, ordinance, or rules of any municipality, board, body, organization or public officer required or permitted to be made, given, tendered, or filed, with surety or sureties, and whenever the performance of any act, duty, or obligation or the refraining from any act is required or permitted to be guaranteed, such bond, undertaking, obligation, recognizance, or guaranty may be executed by a surety insurer qualified to act as surety or guarantor as in this code provided. Such execution by such insurer of such bond, undertaking, obligation, recognizance, or guaranty shall be in all respects a full and complete compliance with every requirement of the law, charter, ordinance, or rule that such bond, undertaking, obligation, recognizance, or guaranty shall be executed by one surety or by one or more sureties or that such surety shall be a resident or householder or freeholder, or either or both, or possessed of any other qualifications. All courts, judges, heads of departments, boards, bodies, municipalities, and public officers of every character shall accept and treat accordingly such bond, undertaking, obligation, recognizance, or guaranty when so executed by such insurer, as conforming to and fully and completely complying with every such requirement of every such law, charter, ordinance, or rule.

(2) A surety insurer may be released from its liability on a bond referred to in this section upon the same terms and conditions as are by law prescribed for the release of individual sureties.

History: **En. Secs. 413, 414, Ch. 286, L. 1959; R.C.M. 1947, 40-4502, 40-4503.**

Cross-References

Official bonds — general provisions, Title 2, ch. 9, parts 5 through 8.

33-26-105. Surety companies not permitted to furnish bonds where indemnity required. No foreign or other surety company shall be permitted to furnish the bond for any state, county, or city official, where such company requires in addition to the payment of reasonable premiums any indemnity or other security.

History: **En. Sec. 1, Ch. 6, L. 1911; re-en. Sec. 6234, R.C.M. 1921; re-en. Sec. 6234, R.C.M. 1935; R.C.M. 1947, 40-1725.**

Cross-References

Indemnity defined, 28-11-301.

33-26-106. Cost of surety bond to be allowed in account of officer. Any court or officer whose duty it is to pass upon the account of any person or corporation required by law to give a bond may, whenever such person or corporation has given any such surety company as surety upon such bond, allow in the settlement of such account a reasonable sum for the expense of procuring such surety.

History: **En. Sec. 23, Ch. 139, L. 1909; re-en. Sec. 6228, R.C.M. 1921; re-en. Sec. 6228, R.C.M. 1935; R.C.M. 1947, 40-1724.**

33-26-107. Deposit of money in bank for safekeeping by executors and other fiduciaries on agreement with surety. It is lawful for any executor, administrator, guardian, receiver, trustee, or other party of whom a bond, undertaking, or other obligation is required to agree with the entity's surety or sureties for the deposit of any or all money and assets for which the entity and the surety or sureties are or may be held responsible with a bank, savings bank, safe-deposit, or trust company, authorized by law to do business, or with another depository approved by the court or a judge, if the deposit is otherwise proper, for safekeeping, and in a manner that prevents the withdrawal of the money or assets or any part of the money or assets without the written consent of the surety or sureties or an order of court or a judge made on notice to the surety or sureties that the court or judge may direct. The agreement may not in any manner release from or change the liability of the principal or sureties as established by the terms of the bond.

History: **En. Sec. 1, Ch. 146, L. 1943; R.C.M. 1947, 40-1703; amd. Sec. 1241, Ch. 56, L. 2009.**

33-26-108. Rulemaking authority for surety insurers. The commissioner may adopt rules regarding surety insurers who sell, solicit, or negotiate commercial bail bonds and effect arrests or surrenders pursuant to Title 46, chapter 9. The rules must include but are not limited to rules regarding the receipt of collateral, the description of collateral received, the penalty for failure to return collateral, an annual list of forfeitures of bonds, and the form and manner for reporting surrenders and arrests effected under Title 46, chapter 9.

History: **En. Sec. 4, Ch. 427, L. 2003; amd. Sec. 5, Ch. 592, L. 2023.**

33-26-109. Surety bail bond premium — fees or interest. A surety bail bond producer that collects any fees or interest other than the minimum premium shall disclose the fees or interest at the time the surety bail bond insurance contract is executed. All fees and interest must be acknowledged by all parties to the contract.

History: **En. Sec. 3, Ch. 473, L. 2025.**

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

CHAPTER 27
INDEPENDENT LIABILITY FUND

Part 1 — General Provisions

33-27-101. Short title.
33-27-102. Purpose.
33-27-103. Definitions.
33-27-104. Rules.
33-27-105 through 33-27-110 reserved.
33-27-111. Right to establish independent liability fund.
33-27-112. Establishment of independent liability fund.
33-27-113. Additions to independent liability fund.
33-27-114. Limit on the amount of fund.
33-27-115. Composition of independent liability fund.
33-27-116. Inviolability of fund.

33-27-117. Deduction of costs.
33-27-118. Taxation of independent liability fund contributions.
33-27-119. Termination of independent liability fund.

Part 1
General Provisions

Part Cross-References

Tax liability on termination of independent liability fund, 15-30-2118.

33-27-101. Short title. Sections 15-30-2118, 15-31-117, 15-31-118, and this chapter may be cited as the "Independent Liability Fund Act".

History: En. Sec. 1, Ch. 564, L. 1987; amd. Sec. 50, Ch. 503, L. 2021.

33-27-102. Purpose. The purpose of 15-30-2118, 15-31-117, 15-31-118, and this chapter is to create a means by which small businesses operating in Montana may establish independent liability funds to set aside assets or make investments to meet any liability claims that might be made against the small businesses by third parties.

History: En. Sec. 2, Ch. 564, L. 1987; amd. Sec. 51, Ch. 503, L. 2021.

33-27-103. Definitions. As used in 15-30-2118, 15-31-117, 15-31-118, and this chapter, the following definitions apply:

(1) "Fiscal year" means the 12-month period used by a particular small business in preparing and filing its Montana individual income tax, corporate income tax, or alternative corporate income tax return.

(2) "Independent liability fund" means a collection of money, assets, and investments that has been set aside by a small business to meet the needs of any liability claims, except workers' compensation claims, brought against it by third parties.

(3) "Liability claim" means any legal or extralegal action by a third party asserting a right to compensation for a wrong done to it by a small business with an independent liability fund.

(4) "Small business" means any commercial or nonprofit enterprise qualified to do business in the state and qualified as a small business under the criteria established by the federal small business administration on April 20, 1987.

(5) "Third party" means a person other than an employee or the management of a small business or of a subsidiary or closely related enterprise of a small business.

History: En. Sec. 3, Ch. 564, L. 1987; amd. Sec. 36, Ch. 268, L. 2013; amd. Sec. 52, Ch. 503, L. 2021.

33-27-104. Rules. (1) The commissioner has authority to implement this chapter and to make any rules and regulations required to carry out the purposes of this chapter.

(2) The commissioner shall by rule establish criteria for ascertaining the inviolability and health of each independent liability fund and shall initiate sanctions against funds that are not secure or viable.

History: En. Sec. 19, Ch. 564, L. 1987.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-27-105 through 33-27-110 reserved.

33-27-111. Right to establish independent liability fund. A small business operating in the state may establish an independent liability fund to provide for defense, settlement, or payment of any liability claims against it by a third party.

History: En. Sec. 4, Ch. 564, L. 1987.

33-27-112. Establishment of independent liability fund. A small business shall notify the commissioner, on a form supplied by the commissioner, of its intention to establish an independent liability fund. The small business shall fully and clearly designate the money, assets, or investments it is setting aside for its independent liability fund.

History: En. Sec. 5, Ch. 564, L. 1987.

33-27-113. Additions to independent liability fund. Within the limits provided in 33-27-114, a small business may make such additions to its independent liability fund as it considers appropriate.

History: En. Sec. 6, Ch. 564, L. 1987.

33-27-114. Limit on the amount of fund. The independent liability fund of any small business may not be greater than the larger of the following:

(1) the total of all legally required liability insurance; or

(2) five times the gross sales of the small business in its most recent fiscal year.

History: En. Sec. 7, Ch. 564, L. 1987.

33-27-115. Composition of independent liability fund. The money, assets, and investments contributed to an independent liability fund must meet the criteria established for investments by an insurance company in chapter 12 and must be valued as those assets and investments would be valued.

History: En. Sec. 8, Ch. 564, L. 1987; amd. Sec. 48, Ch. 304, L. 1999.

33-27-116. Inviolability of fund. Once money, assets, or investments have been contributed to an independent liability fund, they may not be used or removed from the fund except in the manner prescribed by 33-27-117 and 33-27-119.

History: En. Sec. 12, Ch. 564, L. 1987.

33-27-117. Deduction of costs. (1) The actual costs of administering an independent liability fund may be deducted from the fund or from income arising out of the money, assets, and investments in the fund. Such costs include the cost of defending against or negotiating a settlement of any liability claim, as well as the full amount of any claim paid.

(2) A small business may not deduct the cost of any in-house administration of its independent liability fund. The commissioner may review any third-party arrangement for administration of an independent liability fund to ascertain whether such costs are deductible under this section.

History: En. Sec. 13, Ch. 564, L. 1987.

33-27-118. Taxation of independent liability fund contributions. The net value of independent liability fund contributions for any given fiscal year is taxed in accordance with 33-2-705(2)(a).

History: En. Sec. 16, Ch. 564, L. 1987; amd. Sec. 3, Ch. 377, L. 2015.

33-27-119. Termination of independent liability fund. (1) A small business with an independent liability fund may terminate the independent liability fund by:

(a) providing a trust to administer any principal remaining in its fund and to pay any outstanding claims for whichever is longer:

(i) any legally required period of insurance coverage; or

(ii) 5 years; or

(b) substituting an equivalent liability insurance policy plus five times the amount of the deductible for any legally required period of insurance coverage or 5 years, whichever is longer.

(2) If an equivalent insurance policy as provided for in subsection (1)(b) cannot be procured for the full period required, the small business shall deposit the estimated premium for the required equivalent insurance policy in a suitable trust account. The trust account must be used to purchase liability insurance for the required period of insurance coverage.

(3) The principal of an independent liability fund must remain inviolate, except as it is needed to pay just claims, for the full applicable termination period as provided in subsection (1). However, income from the principal not needed for administrative costs may be paid during the termination period to the person or persons who are designated to ultimately receive the principal of the fund, and the income is taxable to that person or persons.

History: En. Sec. 17, Ch. 564, L. 1987; amd. Sec. 3, Ch. 111, L. 2001.

CHAPTER 28
CAPTIVE INSURANCE COMPANIES

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Part 1
General Provisions and Licensing

33-28-101. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Affiliated company" means any company in the same corporate system as a parent, an industrial insured, or a member by virtue of common ownership, control, operation, or management.

(2) "Association" means any legal association of sole proprietorships or business entities that has been in continuous existence for at least 1 year unless the 1-year requirement is waived by the commissioner and the members of which collectively, or the association itself:

(a) owns, controls, or holds with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer;

(b) has complete voting control over an association captive insurance company incorporated as a mutual insurer;

(c) constitutes all of the subscribers of an association captive insurance company formed as a reciprocal insurer; or

(d) owns, controls, or holds with power to vote all of the outstanding ownership interests of an association captive insurance company organized as a limited liability company.

(3) "Association captive insurance company" means any company that insures risks of the members and the affiliated companies of members.

(4) "Branch business" means any insurance business transacted by a branch captive insurance company in this state.

(5) "Branch captive insurance company" means any foreign captive insurance company authorized by the commissioner to transact the business of insurance in this state through a business unit with a principal place of business in this state.

(6) "Branch operations" means any business operations of a branch captive insurance company in this state.

(7) (a) "Business entity" means a corporation, limited liability company, or other legal entity formed by an organizational document.

(b) The term does not include a sole proprietor.

(8) "Captive insurance company" means any pure captive insurance company, association captive insurance company, protected cell captive insurance company, special purpose captive insurance company, or industrial insured captive insurance company formed or authorized under the provisions of this chapter.

(9) "Captive reinsurance company" means a captive insurance company authorized in this state that reinsures the risk ceded by any other insurer.

(10) "Captive risk retention group" means a captive insurance risk retention group formed under the laws of this chapter and pursuant to Title 33, chapter 11.

(11) "Cash equivalent" means any short-term, highly liquid investment that is:

(a) readily convertible to known amounts of cash; and

(b) so near to its maturity that it presents insignificant risk of changes in value because of changes in interest rates. Only an investment with an original maturity of 3 months or less qualifies as a cash equivalent.

(12) (a) "Controlled unaffiliated business entity" means a business entity or sole proprietorship:

(i) that is not in a parent's corporate system consisting of the parent and affiliated companies;

(ii) that has an existing, controlling contractual relationship with the parent or an affiliated company; and

(iii) whose risks are managed by a pure captive insurance company.

(b) The commissioner may promulgate rules that further define a controlled unaffiliated business entity.

(13) "Excess workers' compensation insurance" means, in the case of an employer that has insured or self-insured its workers' compensation risks in accordance with applicable state or federal law, insurance that is in excess of a specified per-incident or aggregate limit established by the commissioner.

(14) "Foreign captive insurance company" means any captive insurance company formed under the laws of any jurisdiction other than this state.

(15) "Industrial insured" means an insured:

(a) who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer;

(b) whose aggregate annual premiums for insurance on all risks total at least $25,000; and

(c) who has at least 25 full-time employees.

(16) "Industrial insured captive insurance company" means any company that insures risks of the industrial insureds that comprise the industrial insured group and their affiliated companies.

(17) "Industrial insured group" means any group that meets either of the following:

(a) the group collectively:

(i) owns, controls, or holds with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated as a stock insurer; or

(ii) has complete voting control over an industrial insured captive insurance company incorporated as a mutual insurer; or

(b) the group is a captive risk retention group.

(18) "Member" means a sole proprietorship or business entity that belongs to an association.

(19) "Mutual insurer" means a business entity without capital stock and with a governing body elected by the policyholders.

(20) "Organizational document" means articles of incorporation, articles of organization, a subscribers' agreement, a charter, or any other document that establishes a business entity.

(21) "Parent" means a sole proprietorship, business entity, or individual that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding voting securities of a captive insurance company.

(22) "Participant" means a sole proprietorship or business entity and any affiliates that are insured by a protected cell captive insurance company in which the losses of the participant are limited through a participant contract to the participant's share of the assets of one or more protected cells identified in the participant contract.

(23) "Participant contract" means a contract by which a protected cell captive insurance company insures the risks of a participant and limits the losses of each participant in the contract.

(24) "Protected cell" means a separate account established by a protected cell captive insurance company formed or authorized under the provisions of this chapter, in which an identified pool of assets and liabilities are segregated and insulated, as provided in this chapter, from the remainder of the protected cell captive insurance company's assets and liabilities in accordance with the terms of one or more participant contracts to fund the liability of the protected cell captive insurance company with respect to the participants as set forth in the participant contracts. All protected cells must be incorporated.

(25) "Protected cell assets" means all assets, contract rights, and general intangibles identified with and attributable to a specific protected cell of a protected cell captive insurance company.

(26) "Protected cell captive insurance company" means any captive insurance company:

(a) in which the minimum capital and surplus required by applicable law are provided by one or more sponsors;

(b) that is formed or authorized under the provisions of this chapter;

(c) that insures the risks of separate participants through participant contracts;

(d) that funds its liability to each participant through one or more protected cells and segregates the assets of each protected cell from the assets of other protected cells and from the assets of the protected cell captive insurance company's general account; and

(e) that is incorporated or formed as a limited liability company.

(27) "Protected cell liabilities" means all liabilities and other obligations identified with and attributable to a specific protected cell of a protected cell captive insurance company.

(28) "Pure captive insurance company" means any company that insures risks of its parent and affiliated companies and controlled unaffiliated business entities.

(29) "Sole proprietorship" means an individual doing business in a noncorporate form.

(30) "Special purpose captive insurance company" means a captive insurance company that is formed or authorized under this chapter that does not meet the definition of any other type of captive insurance company defined in this section or is formed by, on behalf of, or for the benefit of a political subdivision of this state.

(31) "Sponsor" means any entity that meets the requirements of 33-28-301 and 33-28-302 and is approved by the commissioner to provide all or part of the capital and surplus required by the applicable law and to organize and operate a protected cell captive insurance company.

History: En. Sec. 1, Ch. 298, L. 2001; amd. Sec. 8, Ch. 383, L. 2003; amd. Sec. 1, Ch. 518, L. 2007; amd. Sec. 1, Ch. 75, L. 2011; amd. Sec. 2, Ch. 229, L. 2015; amd. Sec. 1, Ch. 335, L. 2015; amd. Sec. 29, Ch. 151, L. 2017; amd. Sec. 1, Ch. 223, L. 2019.

33-28-102. Certificates of authority — lines of business — definition. (1) A captive insurance company, when permitted by its organizational document, may apply to the commissioner for a certificate of authority to provide property insurance, casualty insurance, life insurance, disability income insurance, surety insurance, marine insurance, and health insurance coverage or a group health plan as defined in 33-22-140, except that:

(a) a pure captive insurance company may not insure any risks other than those of its parent and affiliated companies and controlled unaffiliated business entities;

(b) an industrial insured captive insurance company may not insure any risks other than those of the industrial insureds that comprise the industrial insured group and their affiliated companies;

(c) an association captive insurance company may not insure any risks other than those of the members or affiliated companies of members;

(d) a special purpose captive insurance company may not provide insurance or reinsurance for risks unless approved by the commissioner;

(e) a captive insurance company or a branch captive insurance company may not:

(i) provide personal lines of insurance, including but not limited to motor vehicle or homeowner's insurance coverage or any component of those coverages;

(ii) accept or cede reinsurance except as provided in 33-28-203;

(iii) provide health insurance coverage or a group health plan unless the captive insurance company or branch captive insurance company is only providing health insurance coverage or a group health plan for the parent company and its affiliated companies; or

(iv) write workers' compensation insurance on a direct basis; and

(f) a protected cell captive insurance company may not insure any risks other than those of its participants.

(2) A captive insurance company may not write any insurance business unless:

(a) it first obtains from the commissioner a certificate of authority under this section;

(b) its board of directors, board of managing members, or a reciprocal insurer's subscribers' advisory committee holds at least one meeting each year in this state;

(c) it maintains its principal place of business in this state; and

(d) it designates a registered agent to accept service of process, files the name and contact information and any subsequent changes regarding the registered agent with the commissioner, and agrees that whenever the registered agent cannot be found with reasonable diligence, the commissioner's office may act as an agent of the captive insurance company with respect to any action or proceeding and may be served in accordance with 33-1-605 and 33-1-606.

(3) (a) Before receiving a certificate of authority and with respect to a captive insurance company formed as a business entity, a captive insurance company shall:

(i) file with the commissioner a certified copy of its organizational documents, a statement under oath of an officer of the business entity showing its financial condition, and any other statements or documents required by the commissioner; and

(ii) submit to the commissioner for approval a description of the coverages, deductibles, coverage limits, and rates, together with any additional information that the commissioner may reasonably require; and

(iii) provide a statement to the commissioner that addresses the following:

(A) the character, reputation, financial standing, and purposes of the organizers;

(B) the character, reputation, financial responsibility, insurance experience, and business qualifications of any officers, directors, or managing members; and

(C) any other factors that the commissioner considers appropriate.

(b) If there is a subsequent material change in any of the items in the description provided for in subsection (3)(a), the captive insurance company shall submit to the commissioner for approval an appropriate revision and may not offer any additional kinds of insurance until the commissioner approves a revision of the description. The captive insurance company shall inform the commissioner of any change in rates within 30 days of the adoption of the change.

(c) In addition to the information required by subsections (3)(a) and (3)(b), each applicant captive insurance company shall file with the commissioner evidence of the following:

(i) the amount and liquidity of its assets relative to the risks to be assumed;

(ii) the adequacy of the expertise, experience, and character of the person or persons who will manage it;

(iii) the overall soundness of its plan of operation;

(iv) the adequacy of the loss prevention programs of its parent, members, or industrial insureds as applicable; and

(v) any other factors considered relevant by the commissioner in ascertaining whether the proposed captive insurance company will be able to meet its policy obligations.

(d) In addition to the information required by this section, each applicant that is a protected cell captive insurance company shall file with the commissioner the following:

(i) a business plan demonstrating how the applicant will account for the loss and expense experience of each protected cell at a level of detail found to be sufficient by the commissioner and how it will report the experience to the commissioner;

(ii) a statement acknowledging that all financial records of the protected cell captive insurance company, including records pertaining to any protected cells, must be made available for inspection or examination by the commissioner or the commissioner's designated agent;

(iii) all contracts or sample contracts between the protected cell captive insurance company and any participants; and

(iv) evidence that expenses will be allocated to each protected cell in a fair and equitable manner.

(e) In addition to the requirements of subsection (3)(a), a captive insurance company formed as a reciprocal insurer must file with the commissioner a certified copy of the power of attorney of its attorney-in-fact, a certified copy of its subscribers' agreement, a statement under oath of its attorney-in-fact showing its financial condition, and any other statements or documents required by the commissioner;

(f) Information submitted pursuant to this subsection (3) must remain confidential and may not be made public by the commissioner or an employee or agent of the commissioner without the written consent of the company, except that:

(i) the information may be discoverable by a party in a civil action or contested case to which the captive insurance company that submitted the information is a party, upon a showing by the party seeking to discover the information that the information sought is relevant to and necessary for the furtherance of the action or case, the information sought is unavailable from other nonconfidential sources, and a subpoena issued by a judicial or administrative officer of competent jurisdiction has been submitted to the commissioner;

(ii) the commissioner may, in the commissioner's discretion, disclose the information to a public officer having jurisdiction over the regulation of insurance in another state or to a public official of the federal government, as long as the public official agrees in writing to maintain the confidentiality of the information and the laws of the state in which the public official serves, if applicable, require the information to be and to remain confidential.

(4) (a) Each captive insurance company, individual series of members as defined in 35-8-102 of a limited liability company, and protected cell shall pay to the commissioner a nonrefundable fee of $200 for the examining, investigating, and processing of its application, and the commissioner is authorized to retain legal, financial, and examination services from outside the department, the reasonable cost of which may be charged to the applicant.

(b) The provisions of Title 33, chapter 1, part 4, apply to examinations, investigations, and processing conducted under the authority of this section. In addition, each captive insurance company, individual series of members as defined in 35-8-102 of a limited liability company, and protected cell shall pay a fee for the year of registration and a renewal fee for each subsequent year of $300.

(5) If the commissioner is satisfied that the documents and statements that the applicant captive insurance company has filed comply with the provisions of this chapter and applicable provisions of Title 33, the commissioner may grant a certificate authorizing the company to do insurance business in this state. The certificate is effective until March 1 of each year and may be renewed upon proper compliance with this chapter.

History: En. Sec. 2, Ch. 298, L. 2001; amd. Sec. 9, Ch. 383, L. 2003; amd. Sec. 4, Ch. 518, L. 2007; amd. Sec. 2, Ch. 28, L. 2009; amd. Sec. 2, Ch. 75, L. 2011; amd. Sec. 20, Ch. 227, L. 2011; amd. Sec. 2, Ch. 335, L. 2015; amd. Sec. 11, Ch. 60, L. 2019; amd. Sec. 2, Ch. 223, L. 2019.

33-28-103. Names of captive insurance companies. A captive insurance company may not adopt a name that is the same, deceptively similar, or likely to be confused with or mistaken for any other existing business name registered in the state of Montana.

History: En. Sec. 3, Ch. 298, L. 2001.

33-28-104. Minimum capital surplus — letter of credit. (1) A captive insurance company may not be issued a certificate of authority unless it possesses and maintains unimpaired paid-in capital and surplus of:

(a) in the case of a pure captive insurance company, not less than $250,000;

(b) in the case of an industrial insured captive insurance company, including a captive risk retention group, not less than $500,000;

(c) in the case of an association captive insurance company, not less than $500,000;

(d) in the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro forma documents, including the nature of the risks to be insured;

(e) in the case of a protected cell captive insurance company, not less than $500,000. However, if the protected cell captive insurance company does not assume any risks, the risks insured by the protected cells are homogenous, and if there are not more than 10 cells, the commissioner may reduce the amount required in this subsection (1)(e) to an amount not less than $250,000.

(f) in the case of a branch captive insurance company, not less than the applicable amount of capital and surplus required in subsections (1)(a) through (1)(e), as determined based upon the organizational form of the foreign captive insurance company. The minimum capital and surplus must be jointly held by the commissioner and the branch captive insurance company in a bank of the federal reserve system approved by the commissioner.

(g) in the case of a captive reinsurance company, not less than 50% of the capital that would be required for that type of captive insurance company.

(2) The commissioner may require additional capital and surplus based upon the type, volume, and nature of insurance business transacted.

(3) Capital and surplus may be in the form of cash, cash equivalent, or an irrevocable letter of credit on a form prescribed by the commissioner and issued by a bank chartered by the state of Montana, a member bank of the federal reserve system, or a bank chartered by another state if that state-chartered bank is approved by the commissioner.

History: En. Sec. 4, Ch. 298, L. 2001; amd. Sec. 10, Ch. 383, L. 2003; amd. Sec. 5, Ch. 518, L. 2007; amd. Sec. 31, Ch. 271, L. 2009; amd. Sec. 3, Ch. 75, L. 2011; amd. Sec. 19, Ch. 169, L. 2013; amd. Sec. 3, Ch. 335, L. 2015; amd. Sec. 3, Ch. 223, L. 2019.

33-28-105. Formation of captive insurance companies. (1) A captive insurance company must be formed or organized as a business entity as provided in this chapter.

(2) An association captive insurance company or an industrial insured captive insurance company may be:

(a) incorporated as a stock insurer with its capital divided into shares and held by the stockholders;

(b) incorporated as a mutual insurer without capital stock, the governing body of which is elected by the members of its association or associations;

(c) organized as a reciprocal insurer under Title 33, chapter 5, except that the requirements of 33-5-201(1) do not apply; or

(d) organized as a manager-managed limited liability company.

(3) A captive insurance company incorporated or organized in this state must be incorporated or organized by at least one incorporator or organizer who is a resident of this state.

(4) The capital stock of a captive insurance company incorporated as a stock insurer may be authorized with no par value.

(5) (a) At least one of the members of the board of directors of a captive insurance company must be a resident of this state. A captive risk retention group must have a minimum of five directors.

(b) In the case of a captive insurance company formed as a limited liability company, at least one of the managers must be a resident of the state. A captive risk retention group formed as a limited liability company is not required to have a manager who is a resident of this state, but the company must maintain a board of directors, of which one board member must be a resident of the state.

(c) In the case of a reciprocal insurer, at least one of the members of the subscribers' advisory committee must be a resident of the state. A captive risk retention group formed as a reciprocal insurer must have a minimum of five members of the subscribers' advisory committee.

(6) (a) A captive insurance company formed as a corporation or another business entity has the privileges and is subject to the provisions of general corporation law or the laws governing other business entities, as well as the applicable provisions contained in this chapter.

(b) In the event of conflict between the provisions of general corporation law or the laws governing other business entities and this chapter, the provisions of this chapter control.

(7) (a) (i) A captive insurance company formed as a reciprocal insurer has the privileges and is subject to the provisions of Title 33, chapter 5, except 33-5-201(1), in addition to the applicable provisions of this chapter. If there is a conflict between Title 33, chapter 5, and this chapter, the provisions of this chapter control.

(ii) The subscribers' agreement or other organizing document of a captive insurance company formed as a reciprocal insurer may authorize a quorum of a subscribers' advisory committee to consist of at least one-third of the number of its members.

(b) A captive risk retention group has the privileges and is subject to the provisions of Title 33, chapter 11, and this chapter. If there is a conflict between Title 33, chapter 11, and this chapter, the provisions of this chapter prevail.

(8) Except as provided in 33-28-111, the provisions of Title 33, chapter 3, pertaining to mergers, consolidations, conversions, mutualizations, and voluntary dissolutions apply in determining the procedures to be followed by captive insurance companies in carrying out any of those transactions.

(9) (a) With respect to a branch captive insurance company, the foreign captive insurance company shall apply to the secretary of state for a certificate of authority to transact business in this state.

(b) A branch captive insurance company established pursuant to the provisions of this chapter to write in this state only insurance or reinsurance of the employee benefit business of its parent and affiliated companies is subject to provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq. In addition to the general provisions of this chapter, the provisions of this section apply to branch captive insurance companies.

(c) A branch captive insurance company may not do any insurance business in this state unless it maintains the principal place of business for its branch operations in this state.

History: En. Sec. 5, Ch. 298, L. 2001; amd. Sec. 11, Ch. 383, L. 2003; amd. Sec. 1, Ch. 205, L. 2005; amd. Sec. 38, Ch. 469, L. 2005; amd. Sec. 6, Ch. 518, L. 2007; amd. Sec. 3, Ch. 28, L. 2009; amd. Sec. 4, Ch. 335, L. 2015; amd. Sec. 30, Ch. 151, L. 2017; amd. Sec. 3, Ch. 304, L. 2017; amd. Sec. 9, Ch. 117, L. 2019; amd. Sec. 4, Ch. 223, L. 2019.

33-28-106. Dividends. (1) A captive insurance company may not pay a dividend out of, or other distribution with respect to, capital or surplus without the prior approval of the commissioner.

(2) Approval of an ongoing plan for the payment of dividends or other distributions must be conditioned upon retention, at the time of each payment, of capital surplus in excess of the amounts specified by or determined in accordance with formulas approved by the commissioner.

History: En. Sec. 6, Ch. 298, L. 2001; amd. Sec. 7, Ch. 518, L. 2007.

33-28-107. Reports and statements. (1) A captive insurance company is not required to make an annual report except as provided in this section.

(2) (a) Except as provided in subsection (2)(b), on or before April 1 of each year, each captive insurance company shall submit to the commissioner a report of its financial condition in a form and manner as required by the commissioner, verified by oath of two of its executive officers. On or before March 1 of each year, a captive risk retention group shall submit to the commissioner a report of its financial condition in a form and manner as required by the commissioner and verified by oath by two of its executive officers.

(b) A captive insurance company, other than a captive risk retention group, may make written application for filing the required report on a fiscal yearend basis. If an alternative reporting date is granted:

(i) the required report is due 90 days after fiscal yearend; and

(ii) in order to provide sufficient information to support the premium tax return, a captive insurance company shall file a report acceptable to the commissioner prior to April 1 of each year for the prior calendar yearend.

(c) Each captive insurance company shall report using generally accepted accounting principles, unless the commissioner requires the use of statutory accounting principles, with any necessary or useful modifications or additions required by the commissioner. The commissioner may also require the report to be supplemented by additional information.

(d) On or before April 1 of each year, each branch captive insurance company shall submit to the commissioner a copy of all reports and statements required to be filed under the laws in which the foreign captive insurance company is formed, verified by oath of two of its executive officers. If the commissioner is satisfied that the annual report filed by the foreign captive insurance company in its domiciliary jurisdiction provides adequate information concerning the financial condition of the foreign captive insurance company, the commissioner may waive the requirement for completion of the captive annual statement for business written in the foreign jurisdiction.

(3) The commissioner shall consider financial statements filed pursuant to this section as confidential.

(4) (a) Captive risk retention groups shall file reports and statements in accordance with Title 33, chapter 2, part 7, except that a captive risk retention group may file using generally accepted accounting principles. The filing may include letters of credit that are established, issued, or confirmed by a bank chartered in this state, a member of the federal reserve system, or a bank chartered by another state if that state-chartered bank is acceptable to the commissioner.

(b) The filings in subsection (4)(a) are required on an annual and quarterly basis.

History: En. Sec. 7, Ch. 298, L. 2001; amd. Sec. 12, Ch. 383, L. 2003; amd. Sec. 8, Ch. 518, L. 2007; amd. Sec. 4, Ch. 28, L. 2009; amd. Sec. 4, Ch. 75, L. 2011; amd. Sec. 21, Ch. 227, L. 2011; amd. Sec. 5, Ch. 223, L. 2019.

33-28-108. Examinations and investigations. (1) (a) Except for captive risk retention groups as provided in subsection (1)(b), the commissioner or some competent person appointed by the commissioner may examine the affairs, transactions, accounts, records, and assets of each captive insurance company as often as the commissioner considers advisable.

(b) The commissioner or some competent person appointed by the commissioner shall examine the affairs, transactions, accounts, records, and assets of each captive risk retention group as often as the commissioner considers advisable, but no less frequently than every 5 years.

(c) The expenses and charges of the examination must be paid to the commissioner by the company or companies examined.

(2) The provisions of Title 33, chapter 1, part 4, apply to examinations conducted under this section.

(3) Except as provided in subsection (4), all examination reports, preliminary examination reports or results, working papers, recorded information, documents, and their copies produced by, obtained by, or disclosed to the commissioner or any other person in the course of an examination made under this section are confidential, are not subject to subpoena, and may not be made public by the commissioner or an employee or agent of the commissioner without the written consent of the company or upon court order.

(4) (a) Subsection (3) does not prevent the commissioner from using information obtained pursuant to this section in furtherance of the commissioner's regulatory authority under Title 33. The commissioner may, in the commissioner's discretion, grant access to information obtained pursuant to this section to public officers having jurisdiction over the regulation of insurance in any other state or country or to law enforcement officers of this state or any other state or agency of the federal government at any time, as long as the officers receiving the information agree in writing to hold it in a manner consistent with this section.

(b) Captive risk retention group reports produced pursuant to the examination requirements of this section are public records as defined in 2-6-1002.

(5) Except as provided in subsection (6), the provisions of this section apply to all business written by a captive insurance company.

(6) The examination for a branch captive insurance company may only be of branch business and branch operations if the branch captive insurance company has satisfied the requirements of 33-28-107(2)(d) to the satisfaction of the commissioner.

(7) As a condition of authorization of a branch captive insurance company, the foreign captive insurance company shall grant authority to the commissioner for examination of the affairs of the foreign captive insurance company in the jurisdiction in which the foreign captive insurance company is formed.

History: En. Sec. 8, Ch. 298, L. 2001; amd. Sec. 13, Ch. 383, L. 2003; amd. Sec. 9, Ch. 518, L. 2007; amd. Sec. 22, Ch. 227, L. 2011; amd. Sec. 5, Ch. 335, L. 2015; amd. Sec. 53, Ch. 348, L. 2015; amd. Sec. 4, Ch. 304, L. 2017; amd. Sec. 1, Ch. 55, L. 2021.

33-28-109. Suspension or revocation of certificate of authority. (1) The certificate of authority of a captive insurance company doing insurance business in this state may be suspended by the commissioner for any of the following reasons:

(a) insolvency or impairment of capital or surplus;

(b) failure to meet and maintain the requirements of 33-28-104;

(c) refusal or failure to submit an annual report, as required by 33-28-107, or any other report or statement required by law or by lawful order of the commissioner;

(d) failure to comply with the provisions of its own charter, bylaws, or other organizational document;

(e) failure to submit to examination or to perform any legal obligation as required by 33-28-108;

(f) use of methods that, although not otherwise specifically prohibited by law, nevertheless render its operation detrimental or its condition unsound with respect to the public or to its policyholders;

(g) failure to pay the tax provided for in 33-28-201; or

(h) failure otherwise to comply with the laws of this state.

(2) If the commissioner finds, upon examination, hearing, or other evidence, that any captive insurance company has committed any of the acts specified in subsection (1), the commissioner may suspend or revoke the company's certificate of authority if the commissioner considers it in the best interest of the public or the policyholders of the captive insurance company.

(3) If the certificate of authority has not been terminated within the period of suspension, the company's certificate of authority may be reinstated if the commissioner finds that the causes of the suspension have been removed or that the insurer is otherwise in compliance with the requirements of this code.

History: En. Sec. 9, Ch. 298, L. 2001; amd. Sec. 6, Ch. 335, L. 2015; amd. Sec. 31, Ch. 151, L. 2017.

33-28-110. Excess workers' compensation insurance — reinsurance of self-insured plans. (1) A captive insurance company may provide excess workers' compensation insurance to its parent and affiliated companies, unless the laws of the state having jurisdiction over the transaction prohibit providing the insurance.

(2) A captive insurance company may reinsure workers' compensation of a qualified self-insured plan of its parent and affiliated companies.

History: En. Sec. 5, Ch. 383, L. 2003; Sec. 33-28-305, MCA 2005; redes. 33-28-110 by Sec. 21(1), Ch. 518, L. 2007.

33-28-111. Captive mergers. (1) A merger between captive stock insurers must meet the requirements of 33-3-217 and 33-28-105, except that the commissioner may provide notice to the public of the proposed merger prior to approval or disapproval of the merger in place of holding a hearing, at the commissioner's discretion.

(2) A merger between captive mutual insurers must meet the requirements of 33-3-218 and 33-28-105, except that the commissioner may provide notice to the public of the proposed merger prior to approval or disapproval of the merger in place of holding a hearing, at the commissioner's discretion.

(3) (a) An association captive insurance company or industrial insured group formed as a stock or mutual insurer may be converted to or merged with a reciprocal insurer pursuant to this section.

(b) A plan for conversion or merger must:

(i) be fair and equitable to the shareholders in the case of a stock insurer or the policyholders in the case of a mutual insurer; and

(ii) provide for the purchase of the shares of any nonconsenting shareholder of a stock insurer or the policyholder interest of any nonconsenting policyholder of a mutual insurer.

(c) In order to convert to a reciprocal insurer, the conversion must be accomplished under a reasonable plan and procedure approved by the commissioner. The commissioner may not approve the plan unless it:

(i) provides for a hearing upon notice to the insurer, directors, officers, and stockholders or policyholders who have the right to appear at the hearing, unless the commissioner waives or modifies the requirements for the hearing;

(ii) provides for the conversion of the existing stockholder or policyholder interests into subscriber interests in the resulting reciprocal insurer proportionate to stockholder or policyholder interests;

(iii) (A) in the case of a stock insurer, is approved by a majority of the shareholders who are entitled to vote and who are represented at a regular or special meeting at which a quorum is present either in person or by proxy; or

(B) in the case of a mutual insurer, by a majority of the voting interests of the policyholders who are represented at a regular or special meeting at which a quorum is present either in person or by proxy; and

(iv) meets the requirements of 33-28-105.

(d) If the commissioner approves a plan of conversion, the certificate of authority for the converting insurer must be amended to state that it is a reciprocal insurer. The conversion is effective and the corporate existence of the converting entity ceases to exist on the date on which the amended certificate is issued to the attorney-in-fact of the reciprocal insurer. The resulting reciprocal insurer shall file the articles of the merger or conversion with the secretary of state.

History: En. Sec. 1, Ch. 151, L. 2017; amd. Sec. 6, Ch. 223, L. 2019.

33-28-112 through 33-28-119 reserved.

33-28-120. Captive insurance regulatory and supervision account. (1) There is an account in the state special revenue fund called the captive insurance regulatory and supervision account, which may be referred to as the captive account.

(2) The purpose of the captive account is to provide the financial means for the commissioner to administer this chapter and for reimbursement of reasonable expenses incurred in promoting captive insurance in this state.

(3) (a) Twenty percent of the premium tax collected under 33-28-201 and all fees and assessments received by the commissioner pursuant to the administration of this chapter must be deposited in the captive account.

(b) All fines and administrative penalties collected pursuant to this chapter must be deposited in the general fund.

(4) All payments from the captive account for the maintenance of staff and associated expenses, including necessary contractual services, may only be disbursed from the state treasury upon warrants issued by the commissioner, after receipt by the commissioner of proper documentation regarding services rendered and expenses incurred.

(5) At the end of each fiscal year, the balance in the captive account must be transferred to the general fund.

History: En. Sec. 2, Ch. 518, L. 2007; amd. Sec. 15, Ch. 6, Sp. L. November 2017; amd. Sec. 1, Ch. 420, L. 2021.

Part 2
Operations

33-28-201. Tax on premiums collected. (1) (a) Each captive insurance company shall pay to the commissioner, on or before March 1 of each year, a tax on the direct premiums collected or contracted for on policies or contracts of insurance written by the captive insurance company during the year ending December 31, after deducting from the direct premiums subject to the tax the amounts paid to policyholders as return premiums, including dividends on unabsorbed premiums or premium deposits returned or credited to policyholders.

(b) The tax on direct premiums collected in this state must be calculated as follows:

(i) 0.4% on the first $20 million; and

(ii) 0.3% on each subsequent dollar collected.

(2) (a) Each captive insurance company shall pay to the commissioner on or before March 1 of each year a tax on assumed reinsurance premiums.

(b) A reinsurance tax does not apply to premiums for risks or portions of risks that are subject to taxation on a direct basis pursuant to subsection (1).

(c) A reinsurance premium tax is not payable in connection with the receipt of assets in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control if the transaction is part of a plan to discontinue the operations of the other insurer and if the intent of the parties to the transaction is to renew or maintain the business with the captive insurance company.

(d) The amount of the reinsurance tax must be calculated as follows:

(i) 0.225% on the first $20 million of assumed reinsurance premiums;

(ii) 0.150% on the next $20 million of assumed reinsurance premiums; and

(iii) 0.050% on each subsequent dollar of assumed reinsurance premiums.

(3) (a) (i) Except as provided in subsections (3)(a)(ii) and (3)(a)(iii), if the aggregate taxes to be paid by a captive insurance company calculated under subsections (1) and (2) amount to less than $5,000 in any year, the captive insurance company shall pay a tax of $5,000 for that year.

(ii) In the calendar year in which a captive insurance company that is subject to the minimum tax is first authorized, the tax must be prorated on a quarterly basis as follows:

(A) $5,000 if authorized in the first quarter;
(B) $3,750 if authorized in the second quarter;
(C) $2,500 if authorized in the third quarter; and
(D) $1,250 if authorized in the fourth quarter.

(iii) In the calendar year in which a captive insurance company that is subject to the minimum tax surrenders its certificate of authority, the tax must be prorated on a quarterly basis as follows:

(A) $1,250 if surrendered in the first quarter;
(B) $2,500 if surrendered in the second quarter;
(C) $3,750 if surrendered in the third quarter; and
(D) $5,000 if surrendered in the fourth quarter.

(b) Each protected cell in a protected cell captive insurance company must be considered separately in determining the aggregate tax to be paid by the protected cell captive insurance company. If the protected cell captive insurance company insures any risks in addition to the protected cells, the determination of the aggregate tax to be paid by the protected cell captive insurance company must also include the premium on those risks.

(c) Each series of members as defined in 35-8-102 of a limited liability company formed as a special purpose captive insurance company must be considered separately pursuant to this section, except that the minimum tax as described in subsection (3)(a) must be considered in the aggregate.

(4) (a) Except as provided in subsection (4)(b), aggregate taxes to be paid by a captive insurance company under this section may not exceed $100,000 in any year.

(b) The provisions of subsection (4)(a) do not apply to:

(i) a protected cell captive insurance company; and

(ii) a special purpose captive insurance company with a series of members as defined in 35-8-102 in a limited liability company.

(5) Two or more captive insurance companies under common ownership and control must be taxed as though they were a single captive insurance company.

(6) For the purposes of this section, "common ownership and control" means:

(a) in the case of stock corporations, the direct or indirect ownership of 80% or more of the outstanding voting stock of two or more corporations by the same shareholder or shareholders; and

(b) in the case of mutual insurers, the direct or indirect ownership of 80% or more of the surplus and the voting power of two or more insurers by the same member or members.

(7) Only the branch business of a branch captive insurance company is subject to taxation under the provisions of this section.

(8) The tax provided for in this section must be calculated on an annual basis notwithstanding policies or contracts of insurance or contracts of reinsurance issued on a multiyear basis. In the case of multiyear policies or contracts, the premium must be prorated for the purposes of determining the tax.

History: En. Sec. 10, Ch. 298, L. 2001; amd. Sec. 14, Ch. 383, L. 2003; amd. Sec. 2, Ch. 205, L. 2005; amd. Sec. 10, Ch. 518, L. 2007; amd. Sec. 5, Ch. 28, L. 2009; amd. Sec. 7, Ch. 335, L. 2015; amd. Sec. 7, Ch. 223, L. 2019; amd. Sec. 1, Ch. 548, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 1, Ch. 548, L. 2025. Amendment effective October 1, 2025.

Applicability: Section 2, Ch. 548, L. 2025, provided: "[This act] applies to tax years beginning after December 31, 2025."

33-28-202. Legal investments. (1) (a) An industrial insured captive insurance company, an association captive insurance company, and a captive risk retention group shall comply with the investment requirements contained in Title 33, chapter 12, and the rules promulgated in accordance with these provisions.

(b) The commissioner may approve the use of alternative reliable methods of valuation and rating.

(c) When a captive insurance company's admitted assets total less than $5 million, the commissioner may approve an investment of up to 20% of admitted assets in rated credit instruments in any one investment that meets the requirements of 33-12-303(1)(c).

(2) A pure captive insurance company or protected cell captive insurance company is not subject to any restrictions on allowable investments, except that the commissioner may prohibit or limit any investment that threatens the solvency or liquidity of the company.

(3) Any captive insurance company may make loans to any of its affiliates. Loans may not be made without prior written approval of the commissioner and must be evidenced by a note in a form approved by the commissioner. Loans of minimum capital and surplus funds required by 33-28-104 are prohibited.

History: En. Sec. 11, Ch. 298, L. 2001; amd. Sec. 39, Ch. 469, L. 2005; amd. Sec. 11, Ch. 518, L. 2007; amd. Sec. 6, Ch. 28, L. 2009; amd. Sec. 5, Ch. 75, L. 2011; amd. Sec. 20, Ch. 169, L. 2013.

33-28-203. Reinsurance. (1) Subject to the prior approval of the commissioner, a captive insurance company may provide reinsurance on risks ceded by any other insurer.

(2) (a) Any captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers complying with the provisions of 33-2-1216 and 33-2-1217.

(b) Prior approval of the commissioner is required for ceding or taking credit for reserves on risks or portions of risks ceded to reinsurers not complying with 33-2-1216 and 33-2-1217.

(3) (a) In addition to the credit allowed to reinsurers in 33-2-1216 and 33-2-1217, a captive insurance company may, if approved by the commissioner, take credit for reserves on risks or portions of risks ceded to a pool, exchange, or association acting as a reinsurer that has been authorized by the commissioner.

(b) The commissioner may require any documents, financial information, or other evidence that a pool, exchange, or association will be able to provide adequate security for its financial obligations.

(c) The commissioner may deny authorization or impose any limitations on the activities of a reinsurance pool, exchange, or association that, in the commissioner's judgment, are necessary and proper to provide adequate security for the ceding captive insurance company and for the protection and consequent benefit of the public at large.

History: En. Sec. 12, Ch. 298, L. 2001.

33-28-204. Rating organizations. A captive insurance company is not required to join a rating organization.

History: En. Sec. 13, Ch. 298, L. 2001.

33-28-205. Exemption from compulsory organizations. A captive insurance company may not join or contribute financially to any plan, pool, association, or guaranty or insolvency fund in this state, and a captive insurance company, its insureds, its parent, any affiliated company, or any member of an association may not receive any benefit from the plan, pool, association, or guaranty or insolvency fund for claims arising out of the operations of the captive insurance company.

History: En. Sec. 14, Ch. 298, L. 2001; amd. Sec. 12, Ch. 518, L. 2007.

33-28-206. Rules. The commissioner may adopt rules necessary to implement the provisions of this chapter. The rules may include but are not limited to rules relating to forms, payment of fees, authorization, capital and surplus, formation of companies, reports, examinations, investigations, redomestications, captive risk retention groups, risk-based capital and holding company systems, letters of credit, risks managed by pure captive insurance companies, standards to ensure that parent or affiliated companies are able to exercise control of the risk management function of any controlled unaffiliated entities to be insured by the pure captive insurance companies, the use of deductible reimbursement with workers' compensation, and suspension and revocation of licenses.

History: En. Sec. 15, Ch. 298, L. 2001; amd. Sec. 13, Ch. 518, L. 2007; amd. Sec. 8, Ch. 335, L. 2015.

33-28-207. Applicable laws. (1) The following apply to captive insurance companies:

(a) the definitions of commissioner and department provided in 33-1-202, property insurance provided in 33-1-210, casualty insurance provided in 33-1-206, life insurance provided in 33-1-208, health insurance coverage and group health plans provided in 33-22-140, and disability income insurance provided in 33-1-235;

(b) the limitation provided in 33-2-705 on the imposition of other taxes;

(c) the provisions relating to supervision, rehabilitation, and liquidation of insurance companies as provided for in Title 33, chapter 2, part 13;

(d) the provisions of 33-1-311, 33-1-604 through 33-1-606, 33-2-112, 33-3-431, 33-18-201, 33-18-203, and 33-18-205;

(e) 33-18-242 only applies to captive risk retention group insurers;

(f) the provisions relating to dissolution and liquidation in Title 33, chapter 3, part 6, except that a pure captive insurance company may proceed with voluntary dissolution and liquidation after prior notice to and approval of the commissioner without following the provisions of Title 33, chapter 3, part 6; and

(g) the authority of the commissioner under 33-2-701(6) to impose a fine for failure to timely file an annual statement, except that the annual statement requirements in 33-28-107 apply.

(2) This chapter may not be construed as exempting a captive insurance company, its parent, or affiliated companies from compliance with the laws governing workers' compensation insurance.

(3) A captive insurance company or branch captive insurance company that writes health insurance coverage or group health plans as defined in 33-22-140 shall comply with applicable state and federal laws.

(4) The following provisions apply to captive risk retention groups:

(a) those relating to actuarial opinions in Title 33, chapter 1, part 14;

(b) those relating to risk-based capital in Title 33, chapter 2, part 19; and

(c) those relating to insurance holding company systems in Title 33, chapter 2, part 11.

(5) Except as expressly provided in this chapter, the provisions of Title 33 do not apply to captive insurance companies.

History: En. Sec. 16, Ch. 298, L. 2001; amd. Secs. 15, 17, Ch. 383, L. 2003; amd. Sec. 3, Ch. 205, L. 2005; amd. Sec. 14, Ch. 518, L. 2007; amd. Sec. 7, Ch. 28, L. 2009; amd. Sec. 23, Ch. 227, L. 2011; amd. Sec. 9, Ch. 335, L. 2015; amd. Sec. 12, Ch. 60, L. 2019; amd. Sec. 8, Ch. 223, L. 2019; amd. Sec. 2, Ch. 356, L. 2023.

Part 3
Protected Cell Captive Insurance Companies

33-28-301. Protected cell captive insurance company. (1) One or more sponsors may form a protected cell captive insurance company.

(2) A protected cell captive insurance company formed or authorized under the provisions of this chapter is subject to the following:

(a) (i) A protected cell captive insurance company may establish one or more protected cells with the prior written approval of the commissioner of a plan of operation or amendments submitted by the protected cell captive insurance company with respect to each protected cell.

(ii) Upon the written approval of the commissioner of the plan of operation, which must include but is not limited to the specific business objectives and investment guidelines of the protected cell, the protected cell captive insurance company in accordance with the approved plan of operation may attribute to the protected cell insurance obligations with respect to its insurance business.

(iii) A protected cell must have its own distinct name or designation that must include the words "protected cell".

(iv) The protected cell captive insurance company shall transfer all assets attributable to a protected cell to one or more separately established and identified protected cell accounts bearing the name or designation of that protected cell. Protected cell assets must be held in the protected cell accounts for the purpose of satisfying the obligations of that protected cell.

(v) An incorporated protected cell may be organized and operated in any form of business organization authorized by the commissioner. Each protected cell of a protected cell captive insurance company must be treated as a captive insurance company for purposes of this chapter, except that the limit on maximum yearly aggregate taxes paid in 33-28-201 does not apply. Unless otherwise permitted by the articles of incorporation or other organizational document of a protected cell captive insurance company, each protected cell of the protected cell captive insurance company must have the same directors, secretary, and registered office as the protected cell captive insurance company.

(b) All attributions of assets and liabilities between a protected cell and the protected cell captive insurance company's general account must be in accordance with the plan of operation and participant contracts approved by the commissioner. No other attribution of assets and liabilities may be made by a protected cell captive insurance company between the protected cell captive insurance company's general account and its protected cells. Any attribution of assets and liabilities between the general account and a protected cell must be in cash or in readily marketable securities with established market values.

(c) The creation of a protected cell creates, with respect to that protected cell, a legal person separate from the protected cell captive insurance company. Amounts attributed to a protected cell under this chapter, including assets transferred to a protected cell account, are owned by the protected cell, and the protected cell captive insurance company may not be a trustee or hold itself out to be a trustee with respect to those protected cell assets of that protected cell account. A protected cell captive insurance company may allow for a security interest to attach to protected cell assets or a protected cell account when the security interest is in favor of a creditor of the protected cell and is otherwise allowed under applicable law.

(d) This chapter may not be construed to prohibit the protected cell captive insurance company from contracting with or arranging for an investment adviser, commodity trading adviser, or other third party to manage the protected cell assets of a protected cell if all remuneration, expenses, and other compensation of the third party are payable from the protected cell assets of that protected cell and not from the protected cell assets of other protected cells or the assets of the protected cell captive insurance company's general account.

(e) (i) A protected cell captive insurance company shall establish administrative and accounting procedures necessary to properly identify the one or more protected cells of the protected cell captive insurance company and the protected cell assets and protected cell liabilities attributable to the protected cells. The directors of a protected cell captive insurance company shall keep protected cell assets and protected cell liabilities:

(A) separate and separately identifiable from the assets and liabilities of the protected cell captive insurance company's general account; and

(B) attributable to one protected cell separate and separately identifiable from protected cell assets and protected cell liabilities attributable to other protected cells.

(ii) If the provisions of this subsection (2)(e) are violated, the remedy of tracing is applicable to protected cell assets commingled with protected cell assets of other protected cells or the assets of the protected cell captive insurance company's general account. The remedy of tracing may not be construed as an exclusive remedy.

(f) When establishing a protected cell, the protected cell captive insurance company shall attribute to the protected cell assets with a value at least equal to the reserves attributed to that protected cell.

(3) Each protected cell must be accounted for separately on the books and records of the protected cell captive insurance company to reflect the financial condition and result of operations of the protected cell, including but not limited to the net income or loss, dividends or other distributions to participants, and any other factor provided in the participant contract or required by the commissioner.

(4) The assets of a protected cell may not be chargeable with liabilities arising from any other insurance business of the protected cell captive insurance company.

(5) A sale, exchange, or other transfer of assets may not be made by a protected cell captive insurance company among any of its protected cells without the consent of the participants of each affected protected cell.

(6) A sale, exchange, transfer of assets, dividend, or distribution may not be made from a protected cell to a sponsor or a participant without the commissioner's prior written approval, which may not be given if the sale, exchange, transfer, dividend, or distribution would result in insolvency or impairment with respect to the protected cell.

(7) Each protected cell captive insurance company shall file annually with the commissioner any financial reports required by the commissioner and shall include, without limitation, accounting statements detailing the financial experience of each protected cell.

(8) Each protected cell captive insurance company shall notify the commissioner in writing within 20 business days from the time that a protected cell has become impaired or insolvent or is otherwise unable to meets its claim or expense obligations.

(9) A participant contract may not take effect without the commissioner's prior written approval.

(10) An addition of each new protected cell or the withdrawal of any participant of an existing protected cell constitutes a change in the business plan of the protected cell captive insurance company and may not be effective without the commissioner's prior written approval.

(11) The business written by a protected cell captive insurance company, with respect to each cell, must be fronted by an insurance company authorized under the laws of any state or approved by the commissioner.

(12) If a protected cell captive insurance company's business is reinsured, with respect to each cell it must be:

(a) reinsured by a reinsurer authorized or approved by the commissioner; or

(b) secured by a trust fund in the United States for the benefit of policyholders and claimants, which must be funded by an irrevocable letter of credit or other asset that is acceptable to the commissioner, and subject to the following:

(i) the amount of the security provided by the trust fund may not be less than the reserves associated with the liabilities that are not fronted or reinsured, including but not limited to reserves for losses that are allocated for loss adjustment expenses, incurred but not reported losses, and unearned premiums for business written through the participant's protected cell;

(ii) the commissioner may require the protected cell captive insurance company to increase the funding of any trust;

(iii) if the form of security in the trust is a letter of credit, the letter of credit must be established, issued, or confirmed by a bank chartered in this state, a member of the federal reserve system, or a bank chartered by another state if that state-chartered bank is approved by the commissioner; and

(iv) the trust and trust instrument must be in a form and with terms approved by the commissioner.

History: En. Sec. 1, Ch. 383, L. 2003; amd. Sec. 15, Ch. 518, L. 2007; amd. Sec. 6, Ch. 75, L. 2011; amd. Sec. 21, Ch. 169, L. 2013; amd. Sec. 10, Ch. 335, L. 2015; amd. Sec. 9, Ch. 223, L. 2019.

33-28-302. Qualification of sponsors. A sponsor of a protected cell captive insurance company must be an insurer authorized under the laws of any state, a reinsurer authorized under the laws of any state, a captive insurance company formed or authorized under this chapter, an insurance producer licensed under chapter 17 of this title and approved by the commissioner, or any other person approved by the commissioner.

History: En. Sec. 2, Ch. 383, L. 2003; amd. Sec. 16, Ch. 518, L. 2007; amd. Sec. 7, Ch. 75, L. 2011; amd. Sec. 11, Ch. 335, L. 2015.

33-28-303. Delinquency of protected cell captive insurance company. If delinquency proceedings have been taken against a protected cell captive insurance company:

(1) the assets of a protected cell may not be used to pay any expenses other than those attributable to the protected cell; and

(2) the capital and surplus of the protected cell captive insurance company must be available at all times to pay expenses of or claims against the protected cell captive insurance company.

History: En. Sec. 3, Ch. 383, L. 2003; amd. Sec. 17, Ch. 518, L. 2007.

33-28-304. Participants in protected cell captive insurance companies. (1) An individual or business entity may be a participant in a protected cell captive insurance company.

(2) A sponsor may be a participant in a protected cell captive insurance company.

(3) A participant is not required to be a shareholder of a protected cell captive insurance company or its affiliate.

History: En. Sec. 4, Ch. 383, L. 2003; amd. Sec. 18, Ch. 518, L. 2007; amd. Sec. 8, Ch. 75, L. 2011.

33-28-305. Renumbered 33-28-110. Sec. 21(1), Ch. 518, L. 2007.

33-28-306. Repealed. Sec. 11, Ch. 223, L. 2019.

History: **En. Sec. 6, Ch. 383, L. 2003; amd. Sec. 19, Ch. 518, L. 2007; amd. Sec. 32, Ch. 151, L. 2017.**

33-28-307 through 33-28-309 reserved.

33-28-310. Investments by protected cell captive insurance companies. The assets of two or more protected cells may be combined for the purposes of investment by a protected cell captive insurance company, and the combination of the protected cells may not be construed as defeating the segregation of the assets for accounting or other purposes.

History: **En. Sec. 3, Ch. 518, L. 2007.**

Part 4
Dormant Captive Insurers

33-28-401. Dormant captive insurer. (1) As used in this section, unless the context requires otherwise, "dormant captive insurance company" means a captive insurance company, other than a captive risk retention group, that has:

(a) ceased transacting the business of insurance, including the issuance of insurance policies; and

(b) no remaining liabilities associated with insurance business transactions or insurance policies issued prior to the filing of its application for a certificate of dormancy under this section.

(2) A captive insurance company domiciled in Montana that meets the criteria of this section may apply to the commissioner for a certificate of dormancy. The certificate of dormancy is subject to expiration at the end of a consecutive 5-year period and may not be renewed.

(3) (a) A dormant captive insurance company that has been issued a certificate of dormancy shall:

(i) possess and thereafter maintain unimpaired, paid-in capital and surplus of not less than $25,000;

(ii) within 90 days of each fiscal year end, submit to the commissioner a report of its financial condition, verified by oath of two of its executive officers, in a form as may be prescribed by the commissioner; and

(iii) pay $1,000 annual dormancy tax due on or before March 1 of each year for any portion of the preceding year in which the captive insurance company held a certificate of dormancy. Each series of members as defined in 35-8-102 or protected cell as defined in 33-28-101 is considered separate pursuant to this section for purposes of paying the $1,000 annual dormancy tax under a certificate of dormancy. A dormant captive insurance company is not otherwise liable for any annual renewal as provided in 33-28-102.

(b) A dormant captive insurance company that has been issued a certificate of dormancy may not:

(i) be subject to or liable for the payment of any tax under 33-28-201;

(ii) be subject to examinations as provided in 33-28-108.

(4) A dormant captive insurance company shall apply to the commissioner for approval to surrender its certificate of dormancy and resume conducting the business of insurance prior to issuing any insurance policies.

(5) A certificate of dormancy must be revoked if a dormant captive insurance company no longer meets the criteria of this section.

History: **En. Sec. 1, Ch. 304, L. 2017; amd. Sec. 10, Ch. 223, L. 2019.**

CHAPTER 29
RESERVED

CHAPTER 30
HEALTH SERVICE CORPORATIONS

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33-30-1101. Subrogation rights.
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Chapter Cross-References

Jurisdiction of providers of health care benefits, Title 33, ch. 1, part 11.
Licenses — discrimination in issuance prohibited, 49-3-204.
Living will declaration — not required as condition for insurance coverage, 50-9-205.
Living wills — effect on insurance, 50-9-205.

Part 1
General Provisions

33-30-101. Definitions. As used in this chapter, the following definitions apply:

(1) (a) "Health service corporation" means a nonprofit corporation organized or operating for the purposes of establishing and operating a nonprofit plan or plans under which prepaid hospital care, medical-surgical care, and other health care and services, or reimbursement for the preceding care and services, may be furnished to a member or beneficiary.

(b) The term does not include a direct patient care agreement established pursuant to 50-4-107.

(2) "Health services" means the health care and services provided by hospitals or other health care institutions, organizations, associations, or groups and by doctors of medicine, osteopathy, dentistry, chiropractic, optometry, and podiatry; nursing services; licensed acupuncturist services; licensed social worker, licensed professional counselor, or psychologist services; medical appliances, equipment, and supplies; and drugs, medicines, ambulance services, and other therapeutic services and supplies.

(3) "Membership contract" means any agreement, contract, or certificate by which a health service corporation describes the health services or benefits provided to its members or beneficiaries.

History: En. 40-5901 by Sec. 1, Ch. 319, L. 1975; R.C.M. 1947, 40-5901(1) thru (3); amd. Sec. 14, Ch. 544, L. 1983; amd. Sec. 3, Ch. 606, L. 1987; amd. Sec. 2, Ch. 362, L. 1991; amd. Sec. 10, Ch. 262, L. 2021.

Cross-References

Board of Behavioral Health, 2-15-1744.
Nonprofit corporations, Title 35, ch. 2.
Licensing — medical professions, Title 37.
Qualifications and licensing of social workers, Title 37, ch. 39.

33-30-102. Application of chapter — construction of other related laws. (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: 33-2-714; 33-2-1212; 33-3-307; 33-3-308; 33-3-401; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, parts 13, 19, 23, and 24; Title 33, chapter 3, part 6; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 10, 12, 15, 18, 19, 22, and 32, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail.

History: En. 40-5902 by Sec. 2, Ch. 319, L. 1975; R.C.M. 1947, 40-5902; amd. Sec. 3, Ch. 558, L. 1987; amd. Sec. 67, Ch. 379, L. 1995; amd. Sec. 38, Ch. 531, L. 1997; amd. Sec. 63, Ch. 227, L. 2001; amd. Sec. 44, Ch. 380, L. 2003; amd. Sec. 32, Ch. 271, L. 2009; amd. Sec. 32, Ch. 428, L. 2015; amd. Sec. 33, Ch. 151, L. 2017; amd. Sec. 8, Ch. 231, L. 2017; amd. Sec. 8, Ch. 25, L. 2019; amd. Sec. 22, Ch. 415, L. 2019; amd. Sec. 17, Ch. 501, L. 2021.

Compiler's Comments

Contingent Termination Provision Repealed: Section 2, Ch. 35, L. 2025, repealed sec. 48, Ch. 415, L. 2019, which terminated this section on occurrence of a contingency. Effective March 27, 2025.

Contingent Termination: Section 48(1) and (2), Ch. 415, L. 2019, provided: "(1) If a court of final disposition finds that the community engagement requirements provided for in [section 1] [53-6-1308] are invalid, [this act] terminates June 30, 2025.

(2) It is the intent of the legislature that if the contingency provided for in subsection (1) occurs, the legislature has an opportunity to consider issues of program integrity, reform, and cost-effectiveness to determine whether [this act] should continue."

Cross-References

Montana Insurance Code — exception for health service corporations, 33-1-102.
Administrative penalty for failure to pay promptly, 33-18-233.
Insurance information and privacy protection — definitions, 33-19-104.
Medicare supplement insurance minimum standards — definitions, 33-22-903.

33-30-103. Purposes of health service corporation. A health service corporation may be organized for the purposes of:

(1) (a) establishing and operating a voluntary, nonprofit plan or plans under which health services, or reimbursement therefor, are furnished to persons who become members or beneficiaries; or

(b) acting as agent or intermediary for other health service corporations, for governmental body or agency, or for other corporations, associations, partnerships, or individuals in the field of health care and services; and

(2) research, education, or related activity to further objects within the purview of this chapter.

History: En. 40-5903 by Sec. 3, Ch. 319, L. 1975; R.C.M. 1947, 40-5903.

33-30-104. No profit organization may be a health service corporation. No group, association, or organization created for or engaged in business or activity for profit, provision for the incorporation of which is made by any of the corporation laws of this state, may be organized or operated, directly or indirectly, as a health service corporation under this chapter.

History: En. 40-5904 by Sec. 4, Ch. 319, L. 1975; R.C.M. 1947, 40-5904.

Cross-References

Nonprofit corporations, Title 35, ch. 2.

33-30-105. Examination of health service corporation. (1) If the commissioner believes a health service corporation is unable or potentially unable to fulfill its contractual obligations to its members, the commissioner may conduct an examination of that corporation.

(2) In addition to the examination authorized in subsection (1), at least once every 4 years, the commissioner shall conduct an examination of each health service corporation to determine if the corporation is fulfilling its contractual obligations by prompt satisfaction of claims at the highest monetary level consistent with reasonable dues or fees and that the corporation's management exercises appropriate fiscal controls, operations, and personnel policies to ensure that efficient and economic administration restrains overhead costs for the benefit of its members.

(3) Each health service corporation examined and its officers, employees, and insurance producers shall produce and make available to the commissioner or the commissioner's examiners the accounts, records, documents, files, information, assets, and matters in its possession or control relating to the subject of the examination.

(4) The commissioner or the commissioner's examiner shall make a verified report of the examination.

(5) The report must comprise only facts appearing from the books, papers, records, or documents of the corporation examined or ascertained from the testimony, under oath, of individuals concerning its affairs and conclusions and recommendations as warranted by those facts.

(6) The commissioner shall furnish a copy of the proposed report to the corporation examined not less than 20 days prior to its filing in the commissioner's office. If the corporation requests a hearing, in writing, within the 20-day period, the commissioner shall grant a hearing with respect to the report and may not file the report until after the hearing and after modifications, if any, that the commissioner considers proper.

(7) The health service corporation shall pay for each examination conducted pursuant to subsections (1) and (2) in accordance with 33-1-413.

History: En. 40-5912 by Sec. 12, Ch. 319, L. 1975; R.C.M. 1947, 40-5912; amd. Sec. 3, Ch. 452, L. 1981; amd. Sec. 4, Ch. 558, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1242, Ch. 56, L. 2009.

Cross-References

Contested case administrative hearings, 2-4-102; Title 2, ch. 4, part 6.

33-30-106. Montana Administrative Procedure Act applicable. All final administrative actions or decisions of the commissioner under this chapter are subject to judicial review under and in accordance with the Montana Administrative Procedure Act.

History: En. 40-5916 by Sec. 16, Ch. 319, L. 1975; R.C.M. 1947, 40-5916.

Cross-References

Montana Administrative Procedure Act, Title 2, ch. 4.

33-30-107. Annual statement. (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on the national association of insurance commissioners' health blank form with the commissioner of insurance. This annual statement must be completed in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual of the national association of insurance commissioners. The statement must be accompanied by an actuarial opinion attesting to the insurer's reserves.

(2) The health service corporation shall file a statement containing any other information concerning its financial affairs that may be reasonably requested by the commissioner.

(3) (a) Each health service corporation shall file electronic versions of its annual and quarterly financial statements with the national association of insurance commissioners. The date for submission of the annual statement electronic filing is March 1. The dates for submission of the quarterly statement electronic filing are as follows:

(i) the first quarter filing is due May 15;
(ii) the second quarter filing is due August 15; and
(iii) the third quarter filing is due November 15.

(b) The commissioner may exempt health service corporations operating only in Montana from these filing requirements.

(c) The health service corporation shall pay all fees and costs associated with preparing the annual statement and other filings and submitting them to the national association of insurance commissioners.

(4) The commissioner may, after notice and hearing, suspend or revoke a health service corporation's certificate of authority or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health service corporation that fails to file an annual statement as required by this part.

History: En. Sec. 1, Ch. 657, L. 1979; amd. Sec. 68, Ch. 379, L. 1995; amd. Sec. 39, Ch. 531, L. 1997; amd. Sec. 54, Ch. 472, L. 1999; amd. Sec. 64, Ch. 227, L. 2001; amd. Sec. 45, Ch. 380, L. 2003; amd. Sec. 28, Ch. 63, L. 2015.

33-30-108. Certificate required. (1) A person may not act as a health service corporation and a health service corporation may not conduct business in this state except as authorized by a certificate of authority issued by the commissioner.

(2) The commissioner may issue a certificate of authority after the person has complied with the applicable provisions of this title and has submitted an application on a form prescribed by the commissioner.

(3) A health service corporation is entitled to a continuation of its certificate of authority upon payment of the annual continuation fee specified in 33-30-204 on or before March 1 of each year and upon continued compliance with the provisions of this title.

(4) The commissioner may revoke or suspend any certificate of authority issued under this section for violations of this title.

History: En. Sec. 10, Ch. 558, L. 1987; amd. Sec. 69, Ch. 379, L. 1995; amd. Sec. 65, Ch. 227, L. 2001; amd. Sec. 29, Ch. 63, L. 2015.

Cross-References

Compliance with Montana Insurance Code required, 33-1-102.
General powers and duties of Commissioner, 33-1-311.
License fees, 33-30-204.

33-30-109. Health service corporation amended articles. A health service corporation shall submit a copy of any articles of amendment to the commissioner within 5 business days after the articles have been filed with the office of the secretary of state.

History: En. Sec. 3, Ch. 227, L. 2001.

33-30-110 reserved.

33-30-111. Notice of violation — conference. If the commissioner shall for any reason have cause to believe that violation of this chapter has occurred or is threatened, the commissioner may give written notice to the health service corporation and to the representatives or other persons who appear to be involved in the suspected violation to arrange a conference with the alleged violators or their authorized representative for the purpose of attempting to ascertain the facts relating to the suspected violation, and in the event it appears that a violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

History: En. 40-5920 by Sec. 20, Ch. 319, L. 1975; R.C.M. 1947, 40-5920; amd. Sec. 85, Ch. 370, L. 1987; amd. Sec. 8, Ch. 606, L. 1987.

33-30-112. Cease and desist order. (1) The commissioner acting in the name of the state may issue an order directing a health service corporation or a representative of a health service corporation to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.

(2) Within 15 days after service of the order of cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. These hearings shall be conducted under the Montana Administrative Procedure Act.

History: En. 40-5921 by Sec. 21, Ch. 319, L. 1975; R.C.M. 1947, 40-5921; amd. Sec. 86, Ch. 370, L. 1987; amd. Sec. 9, Ch. 606, L. 1987.

Cross-References

Contested case administrative proceedings, Title 2, ch. 4, part 6.

33-30-113. Injunctive relief. In the case of any violation of the provisions of this chapter if the commissioner elects not to issue a cease and desist order or in the event of noncompliance with a cease and desist order issued under this chapter, the commissioner may institute a proceeding to obtain injunctive relief, receivership, or other appropriate relief in the district court of the county in which the violation occurs or in which the principal place of business of the health service corporation is located. Any proceeding under this section shall conform to the requirements of Title 27, chapter 19 or 20, except that the commissioner shall not be required to allege facts tending to show the lack of an adequate remedy at law or tending to show irreparable damage or loss.

History: En. 40-5922 by Sec. 22, Ch. 319, L. 1975; R.C.M. 1947, 40-5922; amd. Sec. 87, Ch. 370, L. 1987; amd. Sec. 10, Ch. 606, L. 1987.

Cross-References

Legal actions by state agencies — Attorney General to be notified, 25-1-501.
Injunctions, Title 27, ch. 19.
Receivers, Title 27, ch. 20.

Part 2
Finance

33-30-201. Reserves — requirements suspended. (1) The corporation shall maintain at all times unobligated funds adequate to:

(a) provide the hospital, medical-surgical, and other health services made available to its members and beneficiaries; and

(b) meet all costs and expenses.

(2) In addition, reserves of a health service corporation in cash, certificates of deposit, obligations issued or guaranteed by the government of the United States, or other assets approved by the commissioner must be maintained in an amount not less than:

(a) $500,000 or, if authorized under this chapter after October 1, 1999, $750,000; or

(b) an amount equal to 1 month's average income from dues or fees paid to the corporation by its members or beneficiaries, based on an average of the preceding 12 months, whichever is less.

(3) The determination of minimum reserves is subject, as to amounts payable to participating providers of the health services, to any right of the corporation to prorate the amounts under the terms of its health service contracts with providers.

(4) The commissioner may decrease or suspend the requirements of this section if the commissioner finds that the action is in the best interest of the members of the corporation.

History: En. 40-5905 by Sec. 5, Ch. 319, L. 1975; R.C.M. 1947, 40-5905; amd. Sec. 55, Ch. 472, L. 1999; amd. Sec. 30, Ch. 63, L. 2015.

33-30-202. Annual report by certified public accountant. (1) All corporations subject to the provisions of this chapter shall file annually with the commissioner, on or before June 1, a financial statement audited by a certified public accountant pursuant to rules promulgated by the commissioner.

(2) (a) The commissioner may establish rules governing the content and preparation of the report required by subsection (1).

(b) The report must include:

(i) the corporation's financial statements for the most recent calendar year;

(ii) an opinion by the certified public accountant concerning the accuracy and fairness of the corporation's representation of its financial statements; and

(iii) other information that the commissioner specifies by rule.

History: En. 40-5911 by Sec. 11, Ch. 319, L. 1975; R.C.M. 1947, 40-5911; amd. Sec. 70, Ch. 379, L. 1995.

33-30-203. Premium tax exemption. A health service corporation is exempt from all premium taxes.

History: En. 40-5915 by Sec. 15, Ch. 319, L. 1975; R.C.M. 1947, 40-5915.

Cross-References

Premium taxes, 33-2-705.

33-30-204. Fees. (1) Every health service corporation subject to the provisions of this chapter shall pay the following fees to the commissioner for enforcement of the provisions of this chapter:

(a) for a certified copy of any document or other paper filed in the office of the commissioner, per page, 50 cents;

(b) filing of a membership contract, $25;

(c) filing of a membership contract package, $100;

(d) filing annual statement, $25;

(e) issuance of health service corporation certificate of authority, $300; and

(f) annual continuation of health service corporation certificate of authority, $300.

(2) The commissioner shall promptly deposit with the state treasurer, to the credit of the state special revenue fund of the state auditor's office, all fees and certificate of authority fees received under this section.

History: En. 40-5917 by Sec. 17, Ch. 319, L. 1975; R.C.M. 1947, 40-5917; amd. Sec. 1, Ch. 452, L. 1981; amd. Sec. 5, Ch. 558, L. 1987; amd. Sec. 7, Ch. 351, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 71, Ch. 379, L. 1995; amd. Sec. 46, Ch. 380, L. 2003; amd. Sec. 31, Ch. 63, L. 2015.

Cross-References

License required of health service corporations, 33-30-108.

Part 3
Operations

33-30-301. Forms — filing, approval. A copy of all forms of the membership contract or any type of endorsement or rider shall be filed with and approved by the commissioner of this state and the insurance regulator of the state of domicile of the health service corporation in accordance with chapter 1, part 5.

History: En. 40-5906 by Sec. 6, Ch. 319, L. 1975; R.C.M. 1947, 40-5906; amd. Sec. 2, Ch. 452, L. 1981; amd. Sec. 6, Ch. 558, L. 1987.

Cross-References

Contested case administrative hearings, Title 2, ch. 4, part 6.
Initiating judicial review of administrative proceeding, 2-4-702.
Stays of agency opinions — appeals, 2-4-711.

33-30-302. Allowed contracts. (1) A corporation subject to the provisions of this chapter may enter into contracts for the rendering of health services on behalf of its members or beneficiaries with:

(a) hospitals maintained by a governmental body or agency;

(b) hospitals maintained by a nonprofit corporation organized for hospital purposes; or

(c) other corporations, organizations, associations, partnerships, or individuals furnishing health services.

(2) A health service corporation may enter into agreements or contracts with other organizations or corporations licensed to do business in this state or in any other state for:

(a) the transfer of members or beneficiaries;

(b) the reciprocal joint provisions of benefits to the members or beneficiaries of the corporation and of those other organizations or corporations; or

(c) other joint undertakings the corporation's board of directors approves.

History: En. 40-5907 by Sec. 7, Ch. 319, L. 1975; R.C.M. 1947, 40-5907.

33-30-303. Grievance procedure for members. Any individual member of a corporation, subject to the provisions of this chapter, who believes that the member is aggrieved by any act or omission of the corporation or its officers, directors, or employees may file a statement in writing of the grievance in the office of the commissioner, and the commissioner may investigate the grievance. An investigation by the commissioner may not act as a bar to any suit in a court of competent jurisdiction instituted by an aggrieved member or as a bar to any defense by the involved corporation.

History: En. 40-5913 by Sec. 13, Ch. 319, L. 1975; R.C.M. 1947, 40-5913; amd. Sec. 1243, Ch. 56, L. 2009.

33-30-304. Nonliability for injuries caused by contractees. A health service corporation is not liable for injuries resulting from neglect, misfeasance, malfeasance, or malpractice on the part of any person, organization, agency, or corporation rendering health services to the health service corporation's members and beneficiaries.

History: En. 40-5914 by Sec. 14, Ch. 319, L. 1975; R.C.M. 1947, 40-5914.

33-30-305. Prohibited trade practices. In order to regulate trade practices of health service corporations the following practices are prohibited:

(1) No person may make, issue, circulate, or cause to be made, issued, or circulated any estimate, circular, or statement misrepresenting:

(a) the terms of any health service corporation membership contract issued or to be issued; or

(b) the benefits or advantages promised thereby.

(2) No person may make any misleading representation or any misrepresentation as to the financial condition of any health service corporation.

(3) No person may make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication or in the form of a notice, circular, pamphlet, letter, or poster or over any radio or television station or in any other way an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of a health service corporation which is untrue, deceptive, or misleading.

(4) No person may make or issue or cause to be made or issued any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions, or benefits contained in any health service corporation membership contract for the purpose of inducing or attempting or tending to induce a member to cancel or convert any membership contract.

(5) No person may file with any public official or make, publish, disseminate, circulate, or deliver to any person or place before the public or cause directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of a health service corporation with intent to deceive.

(6) No person may make any false entry in any book, report, or statement of any health service corporation with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs or any public official to whom that health service corporation is required by law to report or who has authority by law to examine into its condition or into any of its affairs or, with like intent, willfully omit to make a true entry of any material fact pertaining to the business of that health service corporation in any book, report, or statement of the health service corporation.

(7) No person may make, publish, disseminate, or circulate, directly or indirectly, or aid, abet, or encourage the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false or maliciously critical of or derogatory to the financial condition of a health service corporation or of an organization proposing to become a health service corporation and which is calculated to injure any person engaged or proposing to engage in the business of operating a health service corporation.

(8) No person may enter into agreement to commit or by any concerted action commit any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of the operation of health service corporations.

History: En. 40-5918 by Sec. 18, Ch. 319, L. 1975; R.C.M. 1947, 40-5918(intro.), (1) thru (7).

Cross-References
Civil libel actions, 27-1-802.
Unsworn falsification to authorities — crime, 45-7-203.
Criminal defamation, 45-8-212.

33-30-306. Discrimination between individuals — restrictions — ratesetting by commissioner prohibited. (1) No person may knowingly make or permit any unreasonable discrimination between individuals in any classification which may be established by a health service corporation and of essentially the same condition of health in the amount of dues or rates charged for any membership contract or in the benefits payable thereunder or in any of the terms and conditions of such contract or in any manner whatever.

(2) Nothing herein contained shall, however, restrict the right of a health service corporation within the discretion of its board of directors to limit or define the classes of persons who shall be eligible to become members, to limit and to define the benefits which it will furnish, and define such benefits as it undertakes to furnish into classes or kinds. A health service corporation may make available to its members health services, or reimbursement therefor, as the board of directors of that corporation may approve.

(3) Nothing contained in subsection (1) includes within the definition of discrimination any of the following practices:

(a) readjustment of the rate of payment for membership in a health service corporation under a group contract based on the loss or expense experience thereunder at the end of the first or any subsequent contract year thereunder which may be made retroactive only for that contract year;

(b) in the case of membership contracts issued on the preauthorized bank draft or similar plans, making allowance to members in an amount which fairly represents the saving in collection expense;

(c) reduction of the rate of payment for group contracts covering a large number of members, but not exceeding savings in administrative expenses reasonably attributable to these contracts as compared with contracts offering similar benefits to smaller numbers of members;

(d) issuing individual membership contracts on a "salary savings" or payroll deduction plan reasonably commensurate with the savings made by use of such plan.

(4) Nothing in this chapter gives the commissioner power to fix and determine a rate level by classification or otherwise.

History: En. 40-5918, 40-5919 by Secs. 18, 19, Ch. 319, L. 1975; R.C.M. 1947, 40-5918(8), 40-5919.

33-30-307. Repealed. Sec. 9, Ch. 384, L. 2003.

History: En. Sec. 2, Ch. 309, L. 1983; amd. Sec. 7, Ch. 558, L. 1987.

33-30-308 through 33-30-310 reserved.

33-30-311. Insurance producer. A person who, for compensation, solicits membership in a prepayment health service plan offered by a corporation subject to the provisions of this chapter is an insurance producer of that corporation and is subject to the provisions of 33-2-708 and Title 33, chapter 17.

History: En. 40-5908 by Sec. 8, Ch. 319, L. 1975; R.C.M. 1947, 40-5908; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 72, Ch. 379, L. 1995.

33-30-312. Repealed. Sec. 97, Ch. 379, L. 1995.

History: En. 40-5909 by Sec. 9, Ch. 319, L. 1975; R.C.M. 1947, 40-5909; amd. Sec. 8, Ch. 558, L. 1987; amd. Sec. 8, Ch. 509, L. 1989; amd. Sec. 1, Ch. 713, L. 1989.

33-30-313. Repealed. Sec. 97, Ch. 379, L. 1995.

History: En. 40-5910 by Sec. 10, Ch. 319, L. 1975; R.C.M. 1947, 40-5910; amd. Sec. 1, Ch. 713, L. 1989.

Parts 4 through 9 reserved

Part 10
Health Service Corporation Plans

33-30-1001. Newborn infants covered by insurance by health service corporation. A disability insurance plan or group disability insurance plan issued by a health service corporation may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of the persons insured from and after the moment of birth. Each policy must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured person. The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days.

History: **En. Sec. 5, Ch. 74, L. 1973; R.C.M. 1947, 15-2304.1; amd. Sec. 28, Ch. 303, L. 1981; amd. Sec. 73, Ch. 379, L. 1995; amd. Sec. 28, Ch. 416, L. 1997; amd. Sec. 6, Ch. 325, L. 2003.**

Cross-References

Child support enforced by Department of Public Health and Human Services — insurance coverage required, 40-5-208.

33-30-1002. Disability coverage of services received in state institutions — coverage of persons eligible for public medical assistance. (1) It is unlawful for any health service corporation issuing membership contracts in Montana to exclude from coverage in a membership contract services rendered the insured while a resident in a Montana state institution if the services to the insured would be covered by the membership contract if rendered to the insured outside a Montana state institution.

(2) A membership contract is considered issued in Montana if the insured purchasing the membership contract is, at the time of purchase, residing in the state of Montana.

(3) If the exclusion prohibited by this section appears in a membership contract issued in Montana after February 14, 1973, the provision is void and the membership contract will be considered to cover services rendered the insured in a Montana state institution if the services would have been covered if rendered to an insured outside a Montana state institution.

(4) Payment for services rendered in a Montana state institution must be to the same extent and at the same rates, according to the provisions of the membership contract, that would be paid for the services if rendered outside a Montana state institution.

(5) A membership contract issued by a health service corporation on or after July 1, 1979, may not deny or reduce benefits to any member on the ground that the person insured is eligible for or receiving public medical assistance provided under Title 53, chapter 2.

History: **En. Secs. 1, 2, 3, 4, Ch. 50, L. 1973; R.C.M. 1947, 40-4035(part), 40-4036, 40-4037, 40-4038; amd. Sec. 3, Ch. 169, L. 1979; amd. Sec. 1244, Ch. 56, L. 2009.**

Cross-References

State institutions — Department of Public Health and Human Services, 53-1-602.

33-30-1003. Continuation of coverage for persons with disabilities — individual contracts. (1) An individual hospital or medical service plan contract delivered or issued for delivery in this state that provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the contract must also provide in substance that attainment of the limiting age may not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical disability and chiefly dependent upon the subscriber for support and maintenance. Proof of intellectual disability or physical disability and dependency must be furnished to the hospital or medical service plan corporation by the subscriber within 31 days of the child's attainment of the limiting age and subsequently as may be required by the corporation. Proof may not be required more frequently than annually after the 2-year period following the child's attainment of the limiting age.

(2) Notwithstanding any other exemption or contrary law, the provisions of this section have equal application to hospital or medical expense insurance policies and hospital and medical service plan contracts.

History: **(1)En. 40-3738 by Sec. 1, Ch. 298, L. 1971; Sec. 40-3738, R.C.M. 1947; (2)En. Sec. 2, Ch. 298, L. 1971; Sec. 40-3740, R.C.M. 1947; R.C.M. 1947, 40-3738(part), 40-3740; amd. Sec. 24, Ch. 472, L. 1997; amd. Sec. 4, Ch. 68, L. 2013.**

33-30-1004. Continuation of coverage for persons with disabilities — group contracts. (1) A group hospital or medical service plan contract delivered or issued for delivery in this state that provides that coverage of a dependent child of an employee or other member of the covered group terminates upon attainment of the limiting age for dependent children specified in the contract must also provide in substance that attainment of the limiting age may not operate to terminate the coverage of the child while the child is and continues to be both incapable of self-sustaining employment by reason of intellectual disability or physical disability and chiefly dependent upon the employee or member for support and maintenance. Proof of intellectual disability or physical disability and dependency must be furnished to the hospital or medical service plan corporation by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the corporation. Proof may not be required more frequently than annually after the 2-year period following the child's attainment of the limiting age.

(2) Notwithstanding any other exemption or contrary law, the provisions of this section have equal application to hospital or medical expense insurance policies and hospital and medical service plan contracts.

History: (1)En. 40-3739 by Sec. 1, Ch. 298, L. 1971; Sec. 40-3739, R.C.M. 1947; (2)En. Sec. 2, Ch. 298, L. 1971; Sec. 40-3740, R.C.M. 1947; R.C.M. 1947, 40-3739(part), 40-3740; amd. Sec. 25, Ch. 472, L. 1997; amd. Sec. 5, Ch. 68, L. 2013.

33-30-1005. Right of rescission. Each membership contract, other than a group contract, issued for delivery in this state on or after January 1, 1980, must contain a notice stating in substance that if the person to whom the contract is issued is not satisfied for any reason, the person is permitted to return the contract within 10 days of its delivery or a longer period that the contract may provide and to have refunded the amount of the premium paid. A contract returned pursuant to this section is void from the beginning.

History: En. Sec. 2, Ch. 342, L. 1979; amd. Sec. 1245, Ch. 56, L. 2009.

Cross-References

Rescission, 28-2-1711 through 28-2-1716.

33-30-1006. Continuing group coverage after termination. A person covered by a group hospital or medical service plan contract, issued or renewed by a health service corporation after October 1, 1981, may, for a period of 1 year with the consent of the employer or the trustees, continue coverage under the group contract during the person's employment notwithstanding any reduction of the person's regular work schedule to less than the minimum time required to qualify for membership in the group, and the premium charged must be equal to that charged the members of the group.

History: En. Sec. 5, Ch. 579, L. 1981; amd. Sec. 1246, Ch. 56, L. 2009.

33-30-1007. Conversion on termination of eligibility. (1) The group hospital or medical service plan contract issued or renewed by a health service corporation after October 1, 1981, must contain a provision that if the insurance or any portion of it on a person or a person's dependents or family members covered under the policy ceases because of termination of the person's employment or of a person's membership in the class or classes eligible for coverage under the policy as a result of an employer discontinuing the employer's business or as a result of an employer discontinuing the policy issued by the health service corporation and not providing for any other group disability insurance or plan, a person must, if the person has been insured for a period of 3 months and if the person is not insured under another major medical disability insurance policy or plan, be entitled to have issued to the person by the insurer, without evidence of insurability, an individual policy of hospital or medical service insurance on the person or the person's dependents or family members. Application for the individual policy must be made and the first premium tendered to the insurer within 31 days after the termination of group coverage.

(2) The individual policy must, at the option of the insured, be on any of the forms then customarily issued by the insurer to individual policyholders with the exception of those whose eligibility is determined by their affiliation other than by employment with a particular entity. In addition, the health service corporation shall make available a conversion policy as required by subsection (4).

(3) The premium on the individual policy may not be more than 200% of the insurer's then customary rate applicable to the coverage of the individual policy. If the person entitled to conversion under this section has been insured for more than 3 years, the premium may not be more than 150% of the customary rate. The customary rate is that rate that is normally issued for medically underwritten policies without discount for healthy lifestyles.

(4) The health service corporation shall make available an individual conversion policy that provides the level of benefits provided by its lowest cost basic health benefit plan, as defined in 33-22-1803. If the insurer is not a small employer carrier under chapter 22, part 18, the insurer shall make available an individual conversion policy that provides equivalent benefits to a basic health benefit plan. The conversion rate may not exceed 150% of the highest rate charged for that plan.

(5) The premium rate for an individual policy converted from a group plan in accordance with the provisions of subsection (3) may not be increased during the first 6 months of coverage of the individual policy.

History: En. Sec. 6, Ch. 579, L. 1981; amd. Sec. 1, Ch. 309, L. 1983; amd. Sec. 9, Ch. 558, L. 1987; amd. Sec. 2, Ch. 200, L. 1991; amd. Sec. 12, Ch. 527, L. 1995; amd. Sec. 2, Ch. 228, L. 1999; amd. Sec. 6, Ch. 384, L. 2003.

33-30-1008. Preexisting conditions. The converted policy may not exclude, as a preexisting condition, any conditions covered by the group contract.

History: En. Sec. 7, Ch. 579, L. 1981.

33-30-1009. Insured's family — conversion entitlement. Subject to the conditions set forth in this section, the conversion privilege is also available:

(1) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and children whose coverage under the group policy terminates by reason of the death, otherwise to each surviving child whose coverage under the group policy terminates by reason of the death, or if the group policy provides for continuation of dependent's coverage following the employee's or member's death, at the end of the continuation;

(2) to the spouse of the employee or member upon termination of coverage of the spouse, by reason of ceasing to be a qualified family member under the group policy, while the employee or member remains under the group policy, including children whose coverage under the group policy terminates at the same time; or

(3) to a child solely with respect to the child upon termination of the child's coverage by reason of ceasing to be a qualified family member under the group policy if a conversion privilege is not otherwise provided in this section with respect to the termination.

History: En. Sec. 8, Ch. 579, L. 1981; amd. Sec. 1247, Ch. 56, L. 2009.

33-30-1010. Renumbered 33-30-1021. Code Commissioner, 1983.

33-30-1011. Dentists performing services common to both medicine and dentistry. A contract or plan may exclude coverage for dental care or services, but no individual or group membership contract or plan issued or renewed on or after October 1, 1983, may disallow payment to a dentist for health care or services for which a physician would be paid, provided the dentist is licensed under the law of this state to perform such care or service.

History: En. Sec. 1, Ch. 471, L. 1983.

33-30-1012. Repealed. Sec. 4, Ch. 606, L. 1987.

History: En. Sec. 15, Ch. 572, L. 1985.

33-30-1013. Coverage required for services provided by nurse specialists. A health service corporation shall provide, in group and individual insurance contracts, coverage for health services provided by a nurse specialist, as specifically listed in 37-8-202, if health care services that nurse specialists are licensed to perform are covered by the contract.

History: En. Sec. 2, Ch. 329, L. 1987; amd. Sec. 5, Ch. 467, L. 2005.

33-30-1014. Coverage for well-child care. (1) Each disability insurance plan or group disability insurance plan that is delivered, issued for delivery, renewed, extended, or modified in this state by a health service corporation and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 7 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the plan.

(2) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics; and

(b) "well-child care" means the services described in subsection (2) and delivered at the intervals required in that subsection by a physician or a health care professional supervised by a physician.

(6) When a disability insurance plan or group disability insurance plan issued by a health service corporation provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the health service corporation that issued or delivered the policy or certificate is located inside or outside of this state.

History: **En. Sec. 3, Ch. 199, L. 1991; amd. Sec. 4, Ch. 390, L. 2007.**

33-30-1015. Limitation of eligibility on conversion. A person who purchases a policy of insurance under 33-30-1007 ceases to be eligible for a conversion policy if the person insured by the policy:

(1) fails to pay the premium on the policy purchased under 33-30-1007; or

(2) enrolls under another major medical disability insurance policy or plan, except that the person may maintain the conversion policy during any waiting period established under any new disability insurance policy or plan that the insured person purchases.

History: **En. Sec. 4, Ch. 200, L. 1991; amd. Sec. 22, Ch. 399, L. 2007.**

33-30-1016. Coverage for adopted children from time of placement — preexisting conditions. (1) Each individual or group membership contract issued or amended by a health service corporation in this state that provides coverage of dependent children of a member must provide coverage for an adopted child of the member to the same extent as for natural children of the member.

(2) The coverage required by this section must be effective from the date of placement for the purpose of adoption and must continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement.

(3) As used in this section, "placement" has the meaning as defined in 33-22-130.

History: **En. Sec. 2, Ch. 387, L. 1991; amd. Sec. 162, Ch. 480, L. 1997.**

33-30-1017. Coverage required for services provided by naturopathic physicians. A health service corporation shall provide, in group and individual insurance contracts or certificates, coverage for health services provided by a naturopathic physician licensed pursuant to Title 37, chapter 26, if the health care services that naturopathic physicians are licensed to perform are covered by the contract or certificate.

History: **En. Sec. 2, Ch. 459, L. 1999.**

33-30-1018. Coverage required for services provided by physical therapist. A health service corporation shall provide, in group and individual insurance contracts or certificates, coverage for health services provided by a physical therapist licensed pursuant to Title 37, chapter 11, if the health care services that physical therapists are licensed to perform are covered by the contracts or certificates.

History: **En. Sec. 2, Ch. 235, L. 2001.**

33-30-1019. Coverage for services provided under freedom of choice for auxiliary health services. A health service corporation shall provide, in group and individual insurance contracts or certificates, coverage for health services provided by a speech-language pathologist or audiologist licensed pursuant to Title 37, chapter 15, or an addiction counselor licensed under Title 37, chapter 39, if the health care services that speech-language pathologists, audiologists, or addiction counselors are licensed to perform are covered by the contracts or certificates.

History: **En. Sec. 2, Ch. 342, L. 2015; amd. Sec. 18, Ch. 713, L. 2023.**

33-30-1020. Coverage for services provided under freedom of choice for mental health services. A health service corporation shall provide, in group and individual insurance contracts, coverage for health services provided by marriage and family therapists licensed under Title 37, chapter 39, if the health care services that marriage and family therapists are licensed to perform are covered by the contracts.

History: **En. Sec. 2, Ch. 206, L. 2017; amd. Sec. 19, Ch. 713, L. 2023.**

33-30-1021. Applicability. Notwithstanding any provision of Title 33 or other law to the contrary, it shall be lawful for an insurer and insured to agree to any terms in an insurance contract that provides more favorable terms for the benefit of the insured than authorized in Title 33 or other provisions of law.

History: **En. Sec. 9, Ch. 579, L. 1981; MCA 1981, 33-30-1010; redes. 33-30-1021 by Code Commissioner, 1983.**

Part 11

Subrogation — Notice

Part Cross-References

State employee group insurance — subrogation — notice, Title 2, ch. 18, part 9.

Disability insurance — subrogation — notice, Title 33, ch. 22, part 16.

33-30-1101. Subrogation rights. A hospital or medical service plan contract issued by a health service corporation may contain a provision providing that, to the extent necessary for reimbursement of benefits paid to or on behalf of the insured, the health service corporation is entitled to subrogation, as provided for in 33-30-1102, against a judgment or recovery received by the insured from a third party found liable for a wrongful act or omission that caused the injury necessitating benefit payments.

History: **En. Sec. 2, Ch. 365, L. 1987.**

33-30-1102. Notice — shared costs of third-party action — limitation. (1) If an insured intends to institute an action for damages against a third party, the insured shall give the health service corporation reasonable notice of the intention to institute the action.

(2) The insured may request that the health service corporation pay a proportionate share of the reasonable costs of the third-party action, including attorney fees.

(3) A health service corporation may elect not to participate in the cost of the action. If that election is made, the health service corporation waives 50% of any subrogation rights granted to it by 33-30-1101.

(4) The health service corporation's right of subrogation granted in 33-30-1101 may not be enforced until the injured insured has been fully compensated for the insured's injuries.

History: **En. Sec. 4, Ch. 365, L. 1987; amd. Sec. 1248, Ch. 56, L. 2009.**

CHAPTER 31

HEALTH MAINTENANCE ORGANIZATIONS

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Part 1
General Provisions

33-31-101. Short title. This chapter may be cited as the "Montana Health Maintenance Organization Act".

History: En. Sec. 1, Ch. 457, L. 1987.

33-31-102. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Accountable care organization" means a group of health care providers that are willing and capable of accepting accountability for the total cost and quality of care for a defined population.

(2) "Affiliation period" means a period that, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective.

(3) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to 33-31-301(3)(e);

(f) care and treatment of mental illness, alcoholism, and drug addiction;

(g) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(h) preventive health services, including:
(i) immunizations;
(ii) well-child care from birth;
(iii) periodic health evaluations for adults;
(iv) voluntary family planning services;
(v) infertility services; and
(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction;
(i) minimum mammography examination, as defined in 33-22-132;
(j) outpatient self-management training and education for the treatment of diabetes along with certain diabetic equipment and supplies as provided in 33-22-129; and
(k) treatment and medical foods for inborn errors of metabolism. "Medical foods" and "treatment" have the meanings provided for in 33-22-131.
(4) "Commissioner" means the commissioner of insurance of the state of Montana.
(5) "Dependent" has the meaning provided in 33-22-140.
(6) "Enrollee" means a person:
(a) who enrolls in or contracts with a health maintenance organization;
(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or
(c) on whose behalf the health maintenance organization contracts to receive health care services.
(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.
(8) "Health care services" means:
(a) the services included in furnishing medical or dental care to a person;
(b) the services included in hospitalizing a person;
(c) the services incident to furnishing medical or dental care or hospitalization; or
(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.
(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.
(10) (a) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers. This subsection (10) does not limit methods of provider payments made by health maintenance organizations.
(b) The term does not apply to:
(i) a PACE organization or an accountable care organization that has received a waiver pursuant to 33-31-201; or
(ii) a direct patient care agreement established pursuant to 50-4-107.
(11) "Insurance producer" means an individual or business entity appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.
(12) "PACE organization" means an organization, as defined in 42 CFR 460.6, that is authorized by the centers for medicare and medicaid services and the department of public health and human services to operate a program of all-inclusive care for the elderly.
(13) "Person" means:
(a) an individual;
(b) a group of individuals;
(c) an insurer, as defined in 33-1-201;
(d) a health service corporation, as defined in 33-30-101;
(e) a corporation, partnership, facility, association, or trust; or
(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(14) "Plan" means a health maintenance organization operated by an insurer or health service corporation as an integral part of the corporation and not as a subsidiary.

(15) "Point-of-service option" means a delivery system that permits an enrollee of a health maintenance organization to receive health care services from a provider who is, under the terms of the enrollee's contract for health care services with the health maintenance organization, not on the provider panel of the health maintenance organization.

(16) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or advanced practice registered nurse, as specifically listed in 37-8-202, or registered nurse first assistant as defined by the board of nursing under Title 37, chapter 8, who treats any illness or injury within the scope and limitations of the provider's practice or any other person who is licensed or otherwise authorized in this state to furnish health care services.

(17) "Provider panel" means those providers with whom a health maintenance organization contracts to provide health care services to the health maintenance organization's enrollees.

(18) "Purchaser" means the individual, employer, or other entity, but not the individual certificate holder in the case of group insurance, that enters into a health care services agreement.

(19) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent.

History: En. Sec. 2, Ch. 457, L. 1987; amd. Sec. 3, Ch. 34, L. 1989; amd. Sec. 2, Ch. 80, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 1, Ch. 437, L. 1991; amd. Sec. 2, Ch. 663, L. 1991; amd. Sec. 1, Ch. 165, L. 1997; amd. Sec. 3, Ch. 413, L. 1997; amd. Sec. 29, Ch. 416, L. 1997; amd. Sec. 3, Ch. 434, L. 1999; amd. Sec. 3, Ch. 450, L. 2001; amd. Sec. 7, Ch. 356, L. 2007; amd. Sec. 5, Ch. 463, L. 2007; amd. Sec. 1, Ch. 195, L. 2009; amd. Sec. 33, Ch. 271, L. 2009; amd. Sec. 2, Ch. 173, L. 2011; amd. Sec. 1, Ch. 346, L. 2011; amd. Sec. 11, Ch. 262, L. 2021.

Cross-References

Disability insurance — coverage for phenylketonuria treatment, 33-22-131.

33-31-103. Rules. The commissioner may, after notice and hearing, make reasonable rules necessary to effectuate this chapter.

History: En. Sec. 20, Ch. 457, L. 1987; amd. Sec. 2, Ch. 437, L. 1991.

Cross-References

Adoption and publication of rules, Title 2, ch. 4, part 3.

33-31-104. Repealed. Sec. 10, Ch. 437, L. 1991.

History: En. Sec. 27, Ch. 457, L. 1987.

33-31-105 through 33-31-110 reserved.

33-31-111. *(Temporary)* **Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under Title 33, chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, parts 7 and 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Other chapters and provisions of this title apply to health maintenance organizations as follows: Title 33, chapter 1, parts 6, 12, and 13; 33-2-1114; 33-2-1211 and 33-2-1212; Title 33, chapter 2, parts 13, 19, 23, and 24; 33-3-401; 33-3-422; 33-3-431; Title 33, chapter 3, part 6; Title 33, chapter 10; Title 33, chapter 12; 33-15-308; Title 33, chapter 17; Title 33, chapter 19; 33-22-107; 33-22-114; 33-22-128; 33-22-129; 33-22-131; 33-22-136 through 33-22-139; 33-22-141 and 33-22-142; 33-22-152 through 33-22-159; 33-22-180; 33-22-244; 33-22-246 and 33-22-247; 33-22-514 and 33-22-515; 33-22-521; 33-22-523 and 33-22-524; 33-22-526; 33-22-2103; and Title 33, chapter 32.

33-31-111. *(Effective October 1, 2026)* **Statutory construction and relationship to other laws.** (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

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(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) Other chapters and provisions of this title apply to health maintenance organizations as follows: Title 33, chapter 1, parts 6, 12, and 13; 33-2-1114; 33-2-1211 and 33-2-1212; Title 33, chapter 2, parts 13, 19, 23, and 24; 33-3-401; 33-3-422; 33-3-431; Title 33, chapter 3, part 6; Title 33, chapter 10; Title 33, chapter 12; 33-15-308; Title 33, chapter 17; Title 33, chapter 19; 33-22-107; 33-22-114; 33-22-128; 33-22-129; 33-22-131; 33-22-136 through 33-22-139; 33-22-141 and 33-22-142; 33-22-149; 33-22-152 through 33-22-159; 33-22-180; 33-22-244; 33-22-246 and 33-22-247; 33-22-514 and 33-22-515; 33-22-521; 33-22-523 and 33-22-524; 33-22-526; 33-22-2103; and Title 33, chapter 32.

History: En. Sec. 24, Ch. 457, L. 1987; amd. Sec. 74, Ch. 379, L. 1995; amd. Sec. 10, Ch. 198, L. 1997; amd. Sec. 6, Ch. 410, L. 1997; amd. Sec. 4, Ch. 413, L. 1997; amd. Sec. 30, Ch. 416, L. 1997; amd. Sec. 1, Ch. 527, L. 1997; amd. Sec. 40, Ch. 531, L. 1997; amd. Sec. 3, Ch. 178, L. 1999; amd. Sec. 2, Ch. 334, L. 1999; amd. Sec. 5, Ch. 348, L. 1999; amd. Sec. 4, Ch. 434, L. 1999; amd. Sec. 56, Ch. 472, L. 1999; amd. Sec. 66, Ch. 227, L. 2001; amd. Sec. 4, Ch. 336, L. 2001; amd. Sec. 4, Ch. 450, L. 2001; amd. Sec. 7, Ch. 325, L. 2003; amd. Sec. 47, Ch. 380, L. 2003; amd. Sec. 7, Ch. 384, L. 2003; amd. Sec. 8, Ch. 356, L. 2007; amd. Sec. 23, Ch. 399, L. 2007; amd. Sec. 34, Ch. 271, L. 2009; amd. Sec. 4, Ch. 359, L. 2009; amd. Sec. 4, Ch. 97, L. 2013; amd. Sec. 3, Ch. 164, L. 2013; amd. Sec. 5, Ch. 334, L. 2013; amd. Sec. 9, Ch. 363, L. 2013; amd. Sec. 3, Ch. 256, L. 2015; amd. Sec. 33, Ch. 428, L. 2015; amd. Sec. 34, Ch. 151, L. 2017; amd. Sec. 9, Ch. 231, L. 2017; amd. Sec. 7, Ch. 245, L. 2017; amd. Sec. 9, Ch. 25, L. 2019; amd. Sec. 13, Ch. 60, L. 2019; amd. Sec. 4, Ch. 215, L. 2019; amd. Sec. 3, Ch. 209, L. 2021; amd. Sec. 18, Ch. 501, L. 2021; amd. Sec. 2, Ch. 88, L. 2023; amd. Sec. 3, Ch. 179, L. 2023; amd. Sec. 3, Ch. 600, L. 2023; amd. Sec. 6, Ch. 782, L. 2023; amd. Sec. 6, Ch. 709, L. 2025.

Compiler's Comments
2025 Amendment: See 2025 Session Law for amendment made by sec. 6, Ch. 709, L. 2025. Amendment effective October 1, 2026.

33-31-112. Filings and reports as public documents. All applications, filings, and reports required under this chapter, except those that contain trade secrets or privileged or confidential commercial or financial information (other than an annual financial statement that the commissioner may require under 33-31-211), are public documents.

History: En. Sec. 25, Ch. 457, L. 1987.

33-31-113. Confidentiality of medical information. (1) Any data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant obtained from the enrollee, applicant, or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except:

(a) to the extent that it may be necessary to carry out the purposes of this chapter;

(b) upon the express consent of the enrollee or applicant;

(c) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(d) in the event of claim or litigation between the enrollee or applicant and the health maintenance organization wherein the data or information is pertinent.

(2) A health maintenance organization is entitled to claim the same statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

History: En. Sec. 26, Ch. 457, L. 1987.

33-31-114. Coverage for adopted children from time of placement — preexisting conditions. (1) Each health maintenance contract regulated under this chapter must provide coverage for an adopted child of the enrollee to the same extent as for natural children of the enrollee.

(2) The coverage required by this section must be effective from the date of placement for the purpose of adoption and must continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement.

(3) As used in this section, "placement" has the meaning as defined in 33-22-130.

History: En. Sec. 3, Ch. 387, L. 1991; amd. Sec. 163, Ch. 480, L. 1997.

33-31-115. Applicability to managed health care entity. (1) The department of public health and human services may limit the amount, scope, and duration of services provided by a managed health care entity under contract for programs established under Title 53. These services may be less than services required by this title.

(2) The delivery of programs of managed health care services established under Title 53 by a managed health care entity under contract with the department of public health and human services is exempt from the provisions of 33-31-301 and 33-31-321.

History: En. Sec. 10, Ch. 502, L. 1995; amd. Sec. 2, Ch. 577, L. 1999; amd. Sec. 1, Ch. 466, L. 2001; amd. Sec. 4, Ch. 351, L. 2011.

Part 2
Authorization of Health Maintenance Organizations

33-31-201. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first registers with the secretary of state to transact business in this state as a foreign corporation under 35-14-1502.

(2) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

(a) be verified by an officer or authorized representative of the applicant;

(b) be in a form prescribed by the commissioner;
(c) contain:
(i) the applicant's name;
(ii) the location of the applicant's home office or principal office in the United States, if a foreign person;
(iii) the date of organization or incorporation;
(iv) the form of organization, including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors;
(v) the state or country of domicile; and
(vi) any additional information that the commissioner may reasonably require; and
(d) set forth the following information or be accompanied by the following documents, as applicable:

(i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments to those documents, certified by the public officer with whom the originals were filed in the state or country of domicile;

(ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the applicant's internal affairs, certified by its secretary or other officer having custody of the documents;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:
(A) any provider and the applicant; or
(B) any person listed in subsection (2)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter.

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

(viii) a statement reasonably describing the geographic service area or areas to be served, by county, including:

(A) a chart showing the number of primary and specialty care providers, with locations and service areas by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

(ix) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

(x) a description of the complaint procedures to be used as required under 33-31-303;

(xi) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under 33-31-222;

(xii) a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed with the commissioner in accordance with the filing provisions of 33-31-301(2). However, this subsection (2)(d)(xii) does not deprive the health maintenance organization of its right to confidentiality of any proprietary information, and the commissioner may not disclose that proprietary information to any other person. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

(xiii) a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

(xiv) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

(xv) evidence that it can meet the requirement of 33-31-216(10); and

(xvi) any other information that the commissioner may reasonably require to make the determinations required in 33-31-202.

(3) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (2) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, after notice and hearing, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may adopt reasonable rules exempting from the filing requirements of this subsection those items that the commissioner considers unnecessary.

(4) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications to the contracts. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(5) Each health maintenance organization shall maintain at its administrative office and make available to the commissioner upon request executed copies of all provider contracts.

(6) The commissioner may adopt reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner.

(7) (a) The commissioner may waive the requirements of this section for a PACE organization that has entered into a PACE program agreement pursuant to 42 U.S.C. 1396u-4.

(b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver application must be filed and approved annually. The annual renewal process must be completed by June 30 of each year.

(c) The factors that the commissioner may take into account when granting a waiver include but are not limited to the financial condition of the PACE organization, any consumer complaints against the PACE organization, and the length of time the PACE organization has been in business.

(d) The PACE organization shall submit an audited financial statement for the organization as a whole and a financial statement for the PACE program specifically with the initial waiver application and annually on June 30. The commissioner may request additional information necessary to evaluate the waiver request.

(e) The waiver automatically expires if the certification of the PACE organization by the centers for medicare and medicaid services or the department of public health and human services expires or is terminated.

(f) The PACE organization shall notify the commissioner within 30 days if the centers for medicare and medicaid services takes adverse action or issues any warnings regarding the continuation of the PACE organization.

(8) (a) (i) The commissioner may waive the requirements of this section for an accountable care organization. Upon establishment of a medicare shared savings program pursuant to 42 U.S.C. 1395jjj, an accountable care organization shall demonstrate compliance with the program requirements in a manner determined by the commissioner.

(ii) The commissioner shall follow the medicare shared savings program structure in developing compliance criteria needed for obtaining a waiver.

(b) A request for waiver must be submitted in a form prescribed by the commissioner. The waiver application must be filed and approved every 3 years. The renewal process must be completed by June 30 of every third year.

(c) The factors that the commissioner may take into account when granting a waiver include but are not limited to the financial condition of the accountable care organization, any consumer complaints against the organization, and the length of time the organization has been in business.

(d) The accountable care organization shall submit an audited financial statement for the organization as a whole and a financial statement for the accountable care organization program specifically with the initial waiver application and annually by June 30. The commissioner may request additional information necessary to evaluate the waiver request.

(e) The waiver automatically expires if certification of the accountable care organization under the medicare shared savings program or the department of public health and human services expires or is terminated.

History: En. Sec. 3, Ch. 457, L. 1987; amd. Sec. 192, Ch. 368, L. 1991; amd. Sec. 3, Ch. 437, L. 1991; amd. Sec. 1249, Ch. 56, L. 2009; amd. Sec. 2, Ch. 195, L. 2009; amd. Sec. 2, Ch. 346, L. 2011; amd. Sec. 239, Ch. 271, L. 2019; amd. Sec. 32, Ch. 157, L. 2023.

33-31-202. Issuance of certificate of authority. (1) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to 33-31-201 within 180 days after receipt of the application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

(b) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments. This requirement does not apply to the physical or mental health care services provided by a health maintenance organization to a person receiving medicaid services under the Montana medicaid program as established in Title 53, chapter 6.

(c) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with the services;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;
(v) any deposit of cash or securities submitted in accordance with 33-31-216; and
(vi) any additional information that the commissioner may reasonably require.

(d) The enrollees must be afforded an opportunity to participate in matters of policy and operation pursuant to 33-31-222.

(e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the commissioner.

(2) The commissioner may deny a certificate of authority only if the requirements of 33-31-404 are complied with.

(3) The commissioner shall examine each health maintenance organization applying for an initial certificate of authority to do business in this state. In lieu of making an examination under this part of any health maintenance organization domiciled in another state, the commissioner may accept an examination report on the organization prepared by the insurance department of the organization's state of domicile.

History: En. Sec. 4, Ch. 457, L. 1987; amd. Sec. 4, Ch. 437, L. 1991; amd. Sec. 2, Ch. 590, L. 1995; amd. Sec. 57, Ch. 472, L. 1999; amd. Sec. 3, Ch. 577, L. 1999; amd. Sec. 8, Ch. 325, L. 2003.

33-31-203. Powers of insurers and health service corporations. (1) An insurer authorized to transact insurance in this state or a health service corporation authorized to do business in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of this chapter. Notwithstanding any other law which may be inconsistent with this section, two or more insurers, health service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the provision of health care services by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage if the health maintenance organization fails to meet its obligations.

(3) The enrollees of a health maintenance organization constitute a permissible group under this title. The insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers under the contracts described in subsection (2).

(4) Nothing in this section exempts a health maintenance organization that provides health care services from complying with the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

History: En. Sec. 16, Ch. 457, L. 1987.

33-31-204. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2) of this section, a person may not tender for, request, or invite tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation of the agreement, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization.

(2) A person may not enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the acquiring person has filed with the commissioner and has sent to the health maintenance organization information required by 33-2-1104 and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to 33-2-1105.

History: En. Sec. 28, Ch. 457, L. 1987; amd. Sec. 39, Ch. 370, L. 2015.

33-31-205 through 33-31-210 reserved.

33-31-211. Annual statements — revocation for failure to file — penalty for false swearing. (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be completed in accordance with the national association of insurance commissioners' annual statement instructions and the Accounting Practices and Procedures Manual of the national association of insurance commissioners. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may waive any verification under oath.

(2) In addition to the annual statement and unless it is operated by an insurer or a health service corporation as a plan, each authorized health maintenance organization shall file quarterly financial statements electronically with the national association of insurance commissioners. The dates for the electronic submission of the quarterly financial statements are March 1 for the first quarter, May 15 for the second quarter, August 15 for the third quarter, and November 15 for the fourth quarter.

(3) At the time of filing the annual statement required by March 1, the health maintenance organization shall pay the commissioner the fee for filing the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of $100, or may suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed $1,000.

(4) The commissioner may, after notice and hearing, impose a fine not to exceed $5,000 for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement or quarterly financial statement required by law that contains a material statement that is false.

(5) The commissioner may require reports considered reasonably necessary and appropriate to enable the commissioner to carry out the duties required of the commissioner under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan.

History: En. Sec. 9, Ch. 457, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 5, Ch. 413, L. 1997; amd. Sec. 41, Ch. 531, L. 1997; amd. Sec. 58, Ch. 472, L. 1999; amd. Sec. 67, Ch. 227, L. 2001; amd. Sec. 35, Ch. 151, L. 2017.

33-31-212. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment to a certificate of authority, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25;

(d) for annual continuation of certificate of authority, $300.

(2) All fees, miscellaneous charges, fines, penalties, and those amounts received pursuant to 33-31-211(4) and 33-31-405 collected by the commissioner pursuant to this chapter and the rules adopted under this chapter must be deposited in the state special revenue fund to the credit of the state auditor's office.

History: En. Sec. 22, Ch. 457, L. 1987; amd. Sec. 8, Ch. 351, L. 1989; amd. Sec. 6, Ch. 628, L. 1989; amd. Sec. 5, Ch. 437, L. 1991; amd. Sec. 48, Ch. 380, L. 2003; amd. Sec. 36, Ch. 151, L. 2017.

33-31-213 and 33-31-214 reserved.

33-31-215. Investment regulations. Except for a health maintenance organization operated as a plan by a health service corporation, a domestic health maintenance organization may invest its funds only as prescribed in chapter 12.

History: En. Sec. 12, Ch. 457, L. 1987; amd. Sec. 49, Ch. 304, L. 1999.

33-31-216. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation is $200,000.

(3) At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on October 1, 1987, shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

(b) 4% of its estimated annual uncovered expenditures for each year.

(5) The commissioner may waive any of the deposit requirements set forth in subsections (1) through (4) whenever the commissioner is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to ensure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to ensure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least $1 million or achieves a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land, buildings, and equipment of at least $1 million or that has been in operation for at least 10 years and has a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of those health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth. However, the health maintenance organization's total deposit may not be required to exceed the maximum required under this section.

(9) (a) Subject to subsection (9)(b) and unless it is operated by an insurer or a health service corporation as a plan, each health maintenance organization must have a minimum

capital of at least $200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(b) A health maintenance organization licensed under this chapter after October 1, 1999, must have a minimum capital of at least $750,000. The amount required to be deposited with the commissioner under subsection (2) must be included in the calculation of the capital needed to meet the $750,000 minimum.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical underwriting or preexisting limitation requirements.

History: En. Sec. 13, Ch. 457, L. 1987; amd. Sec. 6, Ch. 413, L. 1997; amd. Sec. 59, Ch. 472, L. 1999.

33-31-217 through 33-31-220 reserved.

33-31-221. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include but are not limited to the following:

(a) the purchase, lease, construction, renovation, operation, or maintenance of a hospital, a medical facility, or both, its ancillary equipment, and property that may reasonably be required for its principal office or for purposes that may be necessary in the transaction of the business of the organization;

(b) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing a medical facility or hospital or in furtherance of a program providing health care services to enrollees;

(c) the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization;

(d) the contracting with a person for the performance on its behalf of certain functions, such as marketing, enrollment, and administration;

(e) the contracting with an insurer authorized to transact insurance in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization; and

(f) the offering of other health care services in addition to basic health care services.

(2) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner before exercising a power granted in subsection (1)(a), (1)(b), or (1)(d). The commissioner may, after notice and hearing, within 60 days disapprove the exercise of a power under subsection (1)(a), (1)(b), or (1)(d) only if, in the commissioner's opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may make reasonable rules exempting from the filing requirement of this subsection those activities having a de minimis effect. The commissioner may exempt certain contracts from the filing requirement whenever exercise of the authority granted in this section would have little or no effect on the health maintenance organization's financial condition and ability to meet obligations.

(3) This section does not exempt the activities of a health maintenance organization from any applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

History: En. Sec. 5, Ch. 457, L. 1987; amd. Sec. 1250, Ch. 56, L. 2009.

33-31-222. Governing body. (1) The governing body of a health maintenance organization may include providers or other individuals, or both.

(2) The governing body shall establish a mechanism to give the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

History: En. Sec. 6, Ch. 457, L. 1987.

33-31-223. Fiduciary responsibilities. (1) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in the manner of a fiduciary to the health maintenance organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner. Each bond must be written with at least a 1-year discovery period and, if written with less than a 3-year discovery period, must contain a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, may not take effect prior to the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier cancellation or termination date.

History: **En. Sec. 7, Ch. 457, L. 1987.**

Part 3
Operations

33-31-301. Evidence of coverage — schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner in accordance with 33-1-501.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in 33-22-133;

(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medicaid program as established in Title 53, chapter 6;

(h) a provision requiring coverage for well-child care for children from the moment of birth through at least 7 years of age, including:

(i) a history, a physical examination, developmental assessment and anticipatory guidance, as those terms are defined in 33-22-303, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(ii) routine immunizations according to the schedule recommended by the immunization practices advisory committee of the U.S. department of health and human services;

(i) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(j) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(k) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner in accordance with 33-1-501 and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization

may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) The provisions of 33-1-501 govern the filing and approval of health maintenance organization forms.

(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section.

(8) Prior to issuance of evidence of coverage, written informational materials describing the contract's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner.

History: En. Sec. 8, Ch. 457, L. 1987; amd. Sec. 3, Ch. 590, L. 1995; amd. Sec. 2, Ch. 183, L. 1997; amd. Sec. 60, Ch. 472, L. 1999; amd. Sec. 9, Ch. 325, L. 2003; amd. Sec. 2, Ch. 409, L. 2005; amd. Sec. 5, Ch. 390, L. 2007; amd. Sec. 6, Ch. 463, L. 2007.

33-31-302. Information to enrollees. Each authorized health maintenance organization shall provide to its enrollees 30 days' advance notice in writing of any material change in the operation of the health maintenance organization that will affect them directly.

History: En. Sec. 10, Ch. 457, L. 1987.

33-31-303. Complaint system. (1) (a) Each authorized health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures to resolve written complaints initiated by enrollees. A health maintenance organization may not use a complaint system:

(i) before the commissioner approves it; and

(ii) unless the health maintenance organization describes it in each evidence of coverage issued or delivered to an enrollee in this state.

(b) Each time the health maintenance organization denies a claim or initiates disenrollment, cancellation, or nonrenewal, it shall notify the affected enrollee of the right to file a complaint and the procedure for filing a complaint.

(c) Each health maintenance organization shall acknowledge a complaint within 10 days of receiving it.

(d) Each health maintenance organization shall retain records of all complaints for 3 years and shall develop a summary for each year that must include:

(i) a description of the procedures of the complaint system;

(ii) the total number of complaints handled through the complaint system, a compilation of causes underlying the complaints filed, the date on which each complaint was filed, the date on which each complaint was resolved, the disposition of each complaint filed, the time it took to process each complaint, and a summary of each administrative change made because of a complaint; and

(iii) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that were settled during the year by the health maintenance organization.

(e) The health maintenance organization shall annually on or before March 1 file with the commissioner the summary described in subsection (1)(d) for the preceding year.

(2) The commissioner shall hold in confidence the information provided by the health maintenance organization pursuant to subsection (1)(d)(iii).

(3) The commissioner may examine a complaint system.

History: En. Sec. 11, Ch. 457, L. 1987.

33-31-304. Dual choice. An employer in this state that offers its employees the option to enroll in a health maintenance organization and an employee benefit fund in this state that offers its members the option to enroll in a health maintenance organization may not be required to pay more for health benefits provided by the health maintenance organization than it would otherwise be required to provide by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, if the employer or benefits fund pays to the health maintenance organization chosen by each employee or member an amount equal to the lesser of:

(1) the amount paid on behalf of its other employees or members of health benefits; or

(2) the health maintenance organization's charge for coverage approved by the commissioner pursuant to 33-31-301.

History: En. Sec. 29, Ch. 457, L. 1987.

33-31-305. Dentist participation as provider. A contract for dental care services through a health maintenance organization that is offered, delivered, or renewed under this chapter must allow a dentist to request participation as a provider on the same terms and conditions as those by which other dentists participate. This opportunity for participation must be offered for each contract or plan. Each contract or plan must provide at least one annual period during which a dentist may exercise this right.

History: En. Sec. 2, Ch. 265, L. 1989.

Cross-References

Disability insurance — freedom of choice in selection of practitioners, 33-22-111.

Preferred provider agreements — dental services, 33-22-1706.

33-31-306. Point-of-service option. (1) (a) A health maintenance organization that has at least 10,000 enrollees shall offer a point-of-service option benefit plan to each purchaser of a health care services agreement. The purchaser may accept or reject the addition of a point-of-service option to the health care services agreement.

(b) For the purposes of subsection (1)(a), an enrollee does not include an individual receiving medicaid services under the Montana medicaid program provided for in Title 53, chapter 6, or an individual participating in an approved medicare risk contract administered by a licensed health maintenance organization.

(2) Any difference in premium charged for the point-of-service option benefit plan compared to the premium for a standard health care services agreement may not exceed the expected cost to the insurer of benefits and expenses based on sound actuarial principles.

(3) This section may not be construed to permit a health maintenance organization to offer stand-alone indemnity insurance coverage.

History: En. Sec. 2, Ch. 165, L. 1997.

33-31-307. Affiliation periods. (1) A health maintenance organization that offers health insurance coverage in connection with a group health plan and that does not impose a preexisting condition exclusion allowed by 33-22-246 or 33-22-514 with respect to any particular coverage option may impose an affiliation period for that coverage option if:

(a) the affiliation period is applied uniformly without regard to any health status-related factors; and

(b) the affiliation period does not exceed 2 months, or 3 months in the case of a late enrollee, as defined in 33-22-140.

(2) A health maintenance organization is not required to provide health care services or benefits during the affiliation period, and a premium may not be charged to the participant or beneficiary for any coverage during the affiliation period. An affiliation period begins on the enrollment date and runs concurrently with any waiting period under the plan.

(3) A health maintenance organization may use a method other than an affiliation period to address adverse selection if the method is approved by the commissioner.

(4) The definitions in 33-22-140 apply to this section.

History: En. Sec. 43, Ch. 416, L. 1997.

33-31-308 through 33-31-310 reserved.

33-31-311. Insurance producer license required. An individual or business entity may not act as or represent to the public that the individual or business entity is an insurance producer for a health maintenance organization unless the individual or business entity is:

(1) licensed as a disability insurance producer by the commissioner pursuant to Title 33, chapter 17, parts 1, 2, 4, and 10 through 12, or licensed as an insurance producer as provided in 33-30-311; and

(2) appointed or authorized by the health maintenance organization or other health insurance issuer to sell, solicit, or negotiate health care service agreements on its behalf.

History: En. Sec. 15, Ch. 457, L. 1987; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 153, Ch. 42, L. 1997; amd. Sec. 68, Ch. 227, L. 2001; amd. Sec. 24, Ch. 399, L. 2007; amd. Sec. 35, Ch. 271, L. 2009.

33-31-312. Prohibited practices. (1) A health maintenance organization or representative of a health maintenance organization may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of this chapter:

(a) a statement or item of information is considered to be misleading, whether or not it may be literally untrue if, in the total context in which the statement is made or the item of information is communicated, a reasonable person not possessing special knowledge regarding health care coverage may reasonably understand the statement or item of information as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of or person considering enrollment in a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

(b) an evidence of coverage is considered to be deceptive if, when taken as a whole and with consideration given to typography, format, and language, it can cause a reasonable person not possessing special knowledge regarding health maintenance organizations to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or that the health maintenance organization issuing the evidence of coverage does not regularly make available to enrollees covered under the evidence of coverage.

(2) Title 33, chapter 18, applies to health maintenance organizations and evidences of coverage issued by a health maintenance organization, except to the extent that the commissioner determines that the nature of health maintenance organizations and evidences of coverage render the chapter clearly inappropriate.

(3) A health maintenance organization shall clearly disclose in the evidence of coverage the circumstances under which it may disenroll, cancel, or refuse to renew an enrollee. A health maintenance organization may disenroll, cancel, or refuse to renew an enrollee only if the enrollee:

(a) has failed to pay required premiums by the end of the grace period;

(b) has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the health maintenance organization;

(c) has allowed a nonenrollee to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

(d) has moved outside of the geographical service area of the health maintenance organization;

(e) has violated rules of the health maintenance organization stated in the evidence of coverage;

(f) has violated rules adopted by the commissioner for enrollment in a health maintenance organization; or

(g) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that the enrollee may file a grievance on this matter.

(4) A health maintenance organization may not disenroll an enrollee under subsection (3) for reasons related to the physical or mental condition of the enrollee or for any of the following reasons:

(a) failure of the enrollee to follow a prescribed course of treatment; or

(b) administrative actions, such as failure to keep an appointment.

(5) (a) A health maintenance organization that disenrolls a group certificate holder for any reason not listed in subsection (3) or provided in rules adopted by the commissioner shall make arrangements to provide similar alternate insurance coverage to enrollees. The insurance coverage must be continued until the disenrolled group certificate holder finds its own coverage or a period of 12 months elapses, whichever comes first. The premium on the individual coverage must be at the then-customary rate applicable to the individual coverage offered by the insurer, health service corporation, or health maintenance organization that provides the alternate insurance coverage.

(b) If a health maintenance organization disenrolls an enrollee covered on an individual basis for any reason not listed in subsection (3) or provided in rules adopted by the commissioner, coverage must be continued until the anniversary date of the policy or for 1 year, whichever is earlier. A health maintenance organization that disenrolls an individual enrollee for failure to pay a required premium or for fraudulent statements on the enrollment form need not provide alternate insurance coverage to that enrollee.

(6) A health maintenance organization may not refer to itself as an insurer unless licensed as an insurer or use a name deceptively similar to the name or description of an insurer authorized to transact insurance in this state.

(7) A person may not refer to itself as a health maintenance organization or HMO unless it holds a valid certificate of authority issued by the commissioner.

History: En. Sec. 14, Ch. 457, L. 1987; amd. Sec. 1251, Ch. 56, L. 2009.

33-31-313. Premium increase restriction — exception. (1) A health maintenance organization may not increase a premium for an individual's or an individual's group health care services agreement more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the health maintenance organization in violation of the laws of this state; or

(b) cause the financial impairment of the health maintenance organization to the extent that further transaction of insurance by the health maintenance organization would injure or be hazardous to its enrollees or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, by a court decision, by a state rule, or by a federal regulation.

History: En. Sec. 7, Ch. 413, L. 1997.

33-31-314 through 33-31-320 reserved.

33-31-321. Disclosure standards — health maintenance organizations. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an enrollment form or evidence of coverage may not be delivered or issued for delivery in this state by a health maintenance organization unless an outline of coverage is delivered to the applicant at the time the application is made. The outline of coverage must be filed with the commissioner as required by 33-1-501.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insureds financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant; and

(f) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate health benefit plan.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

History: **En. Sec. 7, Ch. 527, L. 1995.**

33-31-322. Repealed. Sec. 35, Ch. 63, L. 2015.

History: **En. Sec. 10, Ch. 527, L. 1995; amd. Sec. 31, Ch. 416, L. 1997.**

Part 4
Supervision, Rehabilitation, and Liquidation

33-31-401. Examination. (1) The commissioner may examine the affairs of a health maintenance organization as often as is reasonably necessary to protect the interests of the people of this state. The commissioner shall make an examination at least once every 5 years. Similarly, the commissioner shall examine a health maintenance organization operated by an insurer or health service corporation as a plan at least once every 5 years. The provisions of 33-1-408 and 33-1-409 apply to examinations under this section.

(2) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner may administer oaths to and examine the officers and insurance producers of the health maintenance organization and the principals of the providers concerning their business.

(3) (a) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or adopted by the commissioner. The commissioner may present an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any examination.

(b) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (3)(a), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of funds. The amount paid is a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state and restored to the appropriate fund.

(4) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state.

History: **En. Sec. 17, Ch. 457, L. 1987; amd. Sec. 7, Ch. 628, L. 1989; amd. Sec. 1, Ch. 713, L. 1989; amd. Sec. 6, Ch. 437, L. 1991; amd. Sec. 61, Ch. 472, L. 1999; amd. Sec. 69, Ch. 227, L. 2001; amd. Sec. 37, Ch. 151, L. 2017.**

33-31-402. Suspension or revocation of certificate of authority. (1) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if the commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under 33-31-201 and the operation adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner, unless amendments to the submissions have been filed with and approved by the commissioner.

(b) The health maintenance organization issues evidences of coverage or uses a schedule of charges for health care services that do not comply with the requirements of 33-31-301.

(c) The health maintenance organization does not provide or arrange for basic health care services.

(d) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(e) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under 33-31-222.

(f) The health maintenance organization has failed to implement the complaint system required by 33-31-303 to resolve valid complaints in a reasonable manner.

(g) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(h) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(i) The health maintenance organization has otherwise failed to substantially comply with this chapter.

(2) The commissioner may suspend or revoke a certificate of authority only if the commissioner complies with the requirements of 33-31-404.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of suspension, enroll any additional enrollees except newborn infants or other newly acquired dependents of existing enrollees and may not engage in any advertising or solicitation.

(4) If the commissioner revokes the certificate of authority of a health maintenance organization, the health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may not transact further business except as may be essential to the orderly conclusion of its affairs. It may not engage in further advertising or solicitation following the effective date of the order of revocation. The commissioner may by written order permit further operation of the health maintenance organization if the commissioner finds further operation to be in the best interest of enrollees to the extent that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

History: En. Sec. 18, Ch. 457, L. 1987; amd. Sec. 7, Ch. 437, L. 1991; amd. Sec. 1252, Ch. 56, L. 2009.

33-31-403. Supervision, rehabilitation, or liquidation of health maintenance organization. (1) The supervision, rehabilitation, or liquidation of a health maintenance organization is considered to be the supervision, rehabilitation, or liquidation of an insurer and must be conducted under the supervision of the commissioner pursuant to chapter 2, part 13. The commissioner may apply for an order directing the commissioner to supervise, rehabilitate, or liquidate a health maintenance organization upon any one or more grounds set out in 33-2-1321, 33-2-1331, or 33-2-1341 or when in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as a claim by an enrollee if the provider of services agrees not to assert the claim against any enrollee of the health maintenance organization.

History: En. Sec. 19, Ch. 457, L. 1987; amd. Sec. 1253, Ch. 56, L. 2009.

33-31-404. Administrative procedures. (1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist or that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall give written notice to the health maintenance organization specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days after the notice for a hearing on the matter.

(2) After the hearing or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall make written findings and act as the commissioner considers advisable. The commissioner shall mail the written findings to the health maintenance organization. The action of the commissioner is subject to review by the district court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(3) When notice and hearing are required with regard to actions taken by the commissioner under this chapter, the requirements of 33-1-314 through 33-1-316 and Title 33, chapter 1, part

7, apply, except that the formal rules of pleading and evidence must be observed. To the extent that 33-1-314 through 33-1-316 and Title 33, chapter 1, part 7, do not address the notice and hearing requirements of this chapter, the provisions of Title 2, chapter 4, parts 6 and 7, apply.

History: En. Sec. 21, Ch. 457, L. 1987; amd. Sec. 8, Ch. 437, L. 1991; amd. Sec. 1254, Ch. 56, L. 2009.

33-31-405. Penalties and enforcement. (1) The commissioner may, in addition to suspension or revocation of a certificate of authority under 33-31-402, after notice and hearing, impose an administrative penalty in an amount not less than $500 or more than $10,000 if the commissioner gives reasonable notice in writing of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation.

(2) If the commissioner has cause to believe that a violation of this chapter has occurred or is threatened, the commissioner may:

(a) give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation;

(b) arrange a conference with the alleged violators or their authorized representatives to attempt to ascertain the facts relating to the suspected violation; and

(c) if it appears that a violation has occurred or is threatened, arrive at an adequate and effective means of correcting or preventing the violation.

(3) (a) The commissioner may issue an order directing a health maintenance organization or its representative to cease and desist from engaging in an act or practice in violation of this chapter.

(b) Within 15 days after service of the cease and desist order, the respondent may request a hearing to determine whether acts or practices in violation of this chapter have occurred. The hearing must be conducted pursuant to Title 2, chapter 4, part 6, and judicial review must be available as provided by Title 2, chapter 4, part 7.

(4) If a health maintenance organization violates a provision of this chapter and the commissioner elects not to issue a cease and desist order or if the respondent does not comply with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lewis and Clark County.

History: En. Sec. 23, Ch. 457, L. 1987; amd. Sec. 9, Ch. 437, L. 1991; amd. Sec. 1255, Ch. 56, L. 2009.

CHAPTER 32
HEALTH UTILIZATION REVIEW

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Part 1
General Provisions

33-32-101. Purpose. The legislature finds and declares that it is the purpose of this chapter to:

(1) promote the delivery of quality health care in a cost-effective manner;

(2) foster greater coordination between health care providers, third-party payors, and others who conduct utilization review activities;

(3) ensure timely access to health care services;

(4) preserve the integrity of the health care provider and patient relationship;

(5) protect patients, employers, and health care providers by:

(a) ensuring that utilization review activities result in informed decisions on the appropriateness of medical care made by those best qualified to be involved in the utilization review process; and

(b) establishing the use of written clinical criteria for utilization review programs and reviews by appropriate health care providers to ensure a fair and transparent process for patients; and

(6) establish written standards and clinical criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services.

History: **En. Sec. 1, Ch. 665, L. 1991; amd. Sec. 34, Ch. 428, L. 2015; amd. Sec. 1, Ch. 470, L. 2019.**

33-32-102. Definitions. As used in this chapter, the following definitions apply:

(1) "Adverse determination", except as provided in 33-32-402, means:

(a) a determination by a health insurance issuer or its designated utilization review organization that, based on the provided information and after application of any utilization review technique, a requested benefit under the health insurance issuer's health plan is denied, reduced, or terminated or that payment is not made in whole or in part for the requested benefit because the requested benefit does not meet the health insurance issuer's requirement for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness or is determined to be experimental or investigational;

(b) a denial, reduction, termination, or failure to provide or make payment in whole or in part for a requested benefit based on a determination by a health insurance issuer or its designated utilization review organization of a person's eligibility to participate in the health insurance issuer's health plan;

(c) any prospective review or retrospective review of a benefit determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit; or

(d) a rescission of coverage determination.

(2) "Ambulatory review" means a utilization review of health care services performed or provided in an outpatient setting.

(3) "Authorized representative" means:

(a) a person to whom a covered person has given express written consent to represent the covered person;

(b) a person authorized by law to provided substituted consent for a covered person; or

(c) a family member of the covered person, or the covered person's treating health care provider, only if the covered person is unable to provide consent.

(4) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or otherwise complex health conditions.

(5) "Certification" means a determination by a health insurance issuer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, and level of effectiveness.

(6) "Chronic condition" means a condition that lasts 1 year or more and that requires ongoing medical attention or limits activities of daily living.

(7) "Clinical peer" means a physician or other health care provider who:

(a) holds a nonrestricted license in a state of the United States; and

(b) is trained or works in the same or a similar specialty to the specialty that typically manages the medical condition, procedure, or treatment under review.

(8) "Clinical review criteria" means the written policies, written screening procedures, decision abstracts, determination rules, clinical and medical protocols, practice guidelines, or any other criteria or rationale used by a health insurance issuer or its designated utilization review organization to determine the medical necessity of health care services.

(9) "Concurrent review" means a utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or another inpatient or outpatient health care setting.

(10) "Cost sharing" means the share of costs that a covered member pays under the health insurance issuer's health plan, including maximum out-of-pocket, deductibles, coinsurance, copayments, or similar charges, but does not include premiums, balance billing amounts for out-of-network providers, or the cost of noncovered services.

(11) "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health plan.

(12) "Covered person" means a policyholder, a certificate holder, a member, a subscriber, an enrollee, or another individual participating in a health plan.

(13) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives after discharge from a facility.

(14) "Emergency medical condition" has the meaning provided in 33-36-103.

(15) "Emergency services" has the meaning provided in 33-36-103.

(16) "External review" describes the set of procedures provided for in Title 33, chapter 32, part 4.

(17) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health insurance issuer or its designated utilization review organization at the completion of the health insurance issuer's internal grievance process as provided in Title 33, chapter 32, part 3.

(18) "Grievance" means a written complaint or an oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:

(a) availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) claims payment, handling, or reimbursement for health care services; or

(c) matters pertaining to the contractual relationship between a covered person and a health insurance issuer.

(19) "Health care provider" or "provider" means a person, corporation, facility, or institution licensed by the state to provide, or otherwise lawfully providing, health care services, including but not limited to:

(a) a physician, physician assistant, advanced practice registered nurse, health care facility as defined in 50-5-101, osteopath, dentist, nurse, optometrist, chiropractor, podiatrist, physical therapist, psychologist, licensed social worker, speech pathologist, audiologist, licensed addiction counselor, or licensed professional counselor; and

(b) an officer, employee, or agent of a person described in subsection (19)(a) acting in the course and scope of employment.

(20) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease, including the provision of pharmaceutical products or services or durable medical equipment.

(21) "Health insurance issuer" has the meaning provided in 33-22-140.

(22) "Medical necessity" means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, chronic condition, illness, injury, or disease or its symptoms or comorbidities, including minimizing the progression, symptoms, or comorbidities of a health condition, chronic condition, illness, injury, or disease, and that are:

(a) in accordance with generally accepted standards of practice;

(b) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and

(c) not primarily for the economic benefit of the insurer or the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.

(23) "Network" means the group of participating providers providing services to a managed care plan.

(24) "Participating provider" means a health care provider who, under a contract with a health insurance issuer or with its contractor or subcontractor, has agreed to provide health care services to covered persons with the expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health insurance issuer.

(25) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, or any similar entity or combination of entities in this subsection.

(26) "Preservice claim" means a request for benefits or payment from a health insurance issuer for health care services that, under the terms of the health insurance issuer's contract of coverage, requires authorization from the health insurance issuer or from the health insurance issuer's designated utilization review organization prior to receiving the services.

(27) "Prospective review" means a utilization review, medical necessity review, or prior authorization conducted of a preservice claim prior to an admission or a course of treatment.

(28) (a) "Rescission" means a cancellation or the discontinuance of coverage under a health plan that has a retroactive effect.

(b) The term does not include a cancellation or discontinuance under a health plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent that the cancellation or discontinuance is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

(29) (a) "Retrospective review" means a review of medical necessity conducted after services have been provided to a covered person.

(b) The term does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

(30) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a health care provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(31) "Stabilize" means, with respect to an emergency condition, to ensure that no material deterioration of the condition is, within a reasonable medical probability, likely to result from or occur during the transfer of the individual from a facility.

(32) (a) "Urgent care request" means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination could:

(i) seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) subject the covered person, in the opinion of a health care provider with knowledge of the covered person's medical condition, to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b) Except as provided in subsection (32)(c), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health insurance issuer shall apply the judgment of a prudent lay person who possesses an average knowledge of health and medicine.

(c) Any request that a health care provider with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subsection (32)(a) must be treated as an urgent care request.

(33) "Utilization review" means a set of formal techniques designed to monitor the use of or to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinions, certification, concurrent review, case management, discharge planning, or retrospective review.

(34) "Utilization review organization" means an entity that conducts utilization review for one or more of the following:

(a) an employer with employees who are covered under a health benefit plan or health insurance policy;

(b) a health insurance issuer providing review for its own health plans or for the health plans of another health insurance issuer;

(c) a preferred provider organization or health maintenance organization; and

(d) any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider under a policy, plan, or contract.

History: **En. Sec. 2, Ch. 665, L. 1991; amd. Sec. 3, Ch. 23, L. 2001; amd. Sec. 35, Ch. 428, L. 2015; amd. Sec. 38, Ch. 151, L. 2017; amd. Sec. 2, Ch. 470, L. 2019; amd. Sec. 8, Ch. 471, L. 2021; amd. Sec. 4, Ch. 612, L. 2025.**

Compiler's Comments

2025 Amendment — Coordination: See 2025 Session Law for amendment made by sec. 4, Ch. 612, L. 2025. Amendment effective October 1, 2025.

The amendments to this section made by sec. 3, Ch. 274, L. 2025, and sec. 1, Ch. 612, L. 2025, were replaced by sec. 4, Ch. 612, L. 2025, a coordination section.

33-32-103. Utilization review plan. An entity covered under the provisions of this chapter may not conduct a utilization review of health care services provided or to be provided to a patient covered under a contract or plan for health care services issued in this state unless that entity, at all times, maintains and can provide at the commissioner's request a current utilization review plan that includes:

(1) a description of review criteria, standards, and procedures to be used in evaluating proposed or delivered health care services that, to the extent possible, must:

(a) be based on nationally recognized criteria, standards, and procedures;

(b) reflect community standards of care, except that a utilization review plan for health care services under the medicaid program provided for in Title 53 need not reflect community standards of care;

(c) ensure quality of care; and

(d) ensure access to needed health care services;

(2) policies and procedures to ensure that a representative of the entity conducting the utilization review is reasonably accessible to patients and health care providers at all times;

(3) policies and procedures to ensure compliance with all applicable state and federal laws to protect the confidentiality of individual medical records;

(4) a copy of the materials designed to inform applicable patients and health care providers of the requirements of the utilization review plan; and

(5) any other information that may be required by the commissioner that is necessary to implement this chapter.

History: En. Sec. 3, Ch. 665, L. 1991; amd. Sec. 5, Ch. 561, L. 1993; amd. Sec. 36, Ch. 428, L. 2015; amd. Sec. 39, Ch. 151, L. 2017.

33-32-104. Preemption by federal law. If any provision of this chapter is preempted by federal law or regulations as applied to any specific health care service, then the provision of this chapter that is preempted by federal law or regulations does not apply to that health care service but only to the extent of the preemption.

History: En. Sec. 8, Ch. 665, L. 1991; amd. Sec. 37, Ch. 428, L. 2015.

33-32-105. Application — exemptions. (1) Except as provided in subsections (2) and (3), the provisions of this chapter apply to:

(a) a health insurance issuer that offers a health plan and provides or performs utilization review services;

(b) any designee of the health insurance issuer or utilization review organization that performs utilization review functions on the health insurance issuer's behalf; and

(c) a health insurance issuer or its designated utilization review organization that provides or performs prospective review or retrospective review benefit determinations.

(2) A general in-house utilization review for a health care provider, including an in-house utilization review that is conducted by or for a long-term care facility and that is required by regulations for medicare or medicaid, is exempt from the provisions of this chapter as long as the review does not directly result in the approval or denial of payment for health care services for a particular case.

(3) A peer review procedure conducted by a professional society or association of providers is exempt from the provisions of this chapter.

History: En. Sec. 9, Ch. 665, L. 1991; amd. Sec. 38, Ch. 428, L. 2015.

33-32-106. Disclosure of utilization review requirements — drug benefit information. (1) A utilization review organization shall make its current utilization review plan prepared pursuant to 33-32-103, including clinical review criteria, standards, procedures, requirements, and restrictions, readily accessible on its website to covered persons, prospective covered persons, and health care providers. The utilization review plan must be described in detail and in easily understandable language.

(2) If a utilization review organization intends to implement a new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, the entity may not implement the change until it has:

(a) notified health care providers in writing of the new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, no less than 60 days before the new or amended plan is to be implemented; and

(b) updated its website to reflect the new or amended utilization review plan, including any new or amended clinical review criteria, standards, procedures, requirements, or restrictions, to make the information accessible to covered persons, prospective covered persons, and health care providers.

(3) A health insurance issuer or utilization review organization, as applicable, shall display on its public website current prescription drug benefit information, including formulary lists of each prescription drug covered under the health insurance issuer's plan.

History: En. Sec. 6, Ch. 470, L. 2019.

33-32-107. Length of prior authorization. (1) A certification by a utilization review organization approving health care services is valid for at least 6 months from the date the health care provider receives the certification unless the covered person loses coverage under the applicable health plan or health insurance coverage or unless a shorter duration is warranted by the United States food and drug administration guidance or other patient safety concerns.

(2) A certification by a utilization review organization approving a health care service for treatment of a chronic condition is valid for 12 months, unless a shorter duration is warranted by the United States food and drug administration's guidance or other patient safety concerns.

History: En. Sec. 7, Ch. 470, L. 2019; amd. Sec. 4, Ch. 274, L. 2025.

Compiler's Comments

2025 Amendment — Coordination: See 2025 Session Law for amendment made by sec. 4, Ch. 274, L. 2025. Amendment effective January 1, 2026.

The amendment to this section made by sec. 2, Ch. 612, L. 2025, was rendered void by sec. 5, Ch. 612, L. 2025, a coordination section.

33-32-108. *(Effective January 1, 2026)* **Retroactive denials prohibited.** When prior approval for a covered service is required and obtained by or on behalf of a covered person and the covered person undergoes the covered service, the approval is final and the health insurance issuer may not rescind approval after the covered service has been provided. This section does not apply to cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits, if the covered person for whom the prior approval was granted is not covered when the service was provided, or if the covered service provided was not the same covered service that received prior approval, unless it was necessary and incidental.

History: En. Sec. 1, Ch. 319, L. 2025.

Compiler's Comments

Effective Date: Section 5, Ch. 319, L. 2025, provided: "[This act] is effective January 1, 2026."

Applicability: Section 6, Ch. 319, L. 2025, provided: "[This act] applies to health insurance policies issued or renewed on or after [the effective date of this act]." Effective January 1, 2026.

33-32-109. *(Effective January 1, 2026)* **Biologic prescriptions for minors.** (1) Biologic therapies may be prescribed by a treating provider for individuals under 18 years of age as provided in this section. The biologic therapies must meet the following requirements:

(a) the biologic therapies must be approved by the U.S. food and drug administration for use on adults but need not be approved for use on persons under 18 years of age; and

(b) the biologic therapies must be medically necessary, covered benefits and supported by medical literature in at least two peer-reviewed journals demonstrating that the off-label use is both safe and effective for use on persons in the following comparable phases of life age ranges:

(i) infancy, between birth and 2 years of age;

(ii) childhood, from 2 to 12 years of age; and

(iii) adolescence, from 12 to 18 years of age.

(2) Upon receipt of the request for prior authorization and medical records supporting the request and the literature described in section (1)(b), an entity covered under the provisions of this chapter performing a utilization review must approve or deny a request for prior authorization for biologic therapies under subsection (1) in the timeframe set forth in this chapter.

(3) For the purposes of this section, the term "biologic therapies" means a treatment that uses substances made from living organisms to treat disease. These substances may be made in a laboratory or occur naturally in the body.

History: En. Sec. 2, Ch. 319, L. 2025.

Compiler's Comments

Effective Date: Section 5, Ch. 319, L. 2025, provided: "[This act] is effective January 1, 2026."

Applicability: Section 6, Ch. 319, L. 2025, provided: "[This act] applies to health insurance policies issued or renewed on or after [the effective date of this act]." Effective January 1, 2026.

Part 2
Utilization Review — Conduct

33-32-201. Repealed. Sec. 40, Ch. 428, L. 2015.
History: **En. Sec. 4, Ch. 665, L. 1991; amd. Sec. 1, Ch. 378, L. 1993.**

33-32-202. Commissioner not to approve or disapprove plans. Nothing in this chapter may be construed as authorizing the commissioner to approve or disapprove a utilization review plan required in 33-32-103.
History: **En. Sec. 5, Ch. 665, L. 1991.**

33-32-203. Repealed. Sec. 40, Ch. 428, L. 2015.
History: **En. Sec. 6, Ch. 665, L. 1991.**

33-32-204. Repealed. Sec. 40, Ch. 428, L. 2015.
History: **En. Sec. 7, Ch. 665, L. 1991.**

33-32-205. Corporate oversight of utilization review program. A health insurance issuer is responsible for:

(1) monitoring all utilization review activities carried out by or on behalf of the health insurance issuer;

(2) ensuring that all requirements of this part and rules adopted pursuant to this part are met; and

(3) ensuring that appropriate personnel have operational responsibility for the conduct of the health insurance issuer's utilization review program.
History: **En. Sec. 1, Ch. 428, L. 2015.**

33-32-206. Responsibility for contracted services. Whenever a health insurance issuer contracts with a utilization review organization or other entity to perform the utilization review functions required by this part or rules adopted pursuant to this part, the commissioner shall hold the health insurance issuer responsible for monitoring the activities of the utilization review organization or the entity with which the health insurance issuer has contracted and for ensuring that the requirements of this part are met.
History: **En. Sec. 2, Ch. 428, L. 2015.**

33-32-207. Health insurance issuer duties for utilization review. (1) A health insurance issuer that requires a request for benefits under the covered person's health plan to be subjected to utilization review shall implement a utilization review program with written documentation describing all review activities and procedures, both delegated and nondelegated, for:

(a) the filing of benefit requests;

(b) the notification of utilization review and benefit determinations; and

(c) the review of adverse determinations in accordance with Title 33, chapter 32, parts 3 and 4.

(2) The written documentation must describe the following:

(a) procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

(b) data sources and clinical review criteria used in decisionmaking;

(c) mechanisms to ensure consistent application of clinical review criteria and compatible decisions;

(d) data collection processes and analytical methods used in assessing utilization of health care services;

(e) provisions for ensuring confidentiality of clinical and proprietary information;

(f) the organizational structure that periodically assesses utilization review activities and reports to the health insurance issuer's governing body. This organizational structure may include but is not limited to the utilization review committee or a quality assurance committee.

(g) the staff position functionally responsible for day-to-day program management.

(3) A health insurance issuer shall:

(a) file an annual summary report of its utilization review program activities with the commissioner in the format specified by the commissioner;

(b) maintain records for a minimum of 6 years of all benefit requests, claims, and notices associated with utilization review and benefit determinations made in accordance with 33-32-211 and 33-32-212; and

(c) make the records maintained under subsection (3)(b) available, on request, for examination by covered persons, the commissioner, and appropriate federal agencies.

History: En. Sec. 3, Ch. 428, L. 2015.

33-32-208. Operational requirements. (1) A utilization review program must use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to ensure ongoing efficacy. A health insurance issuer may develop its own clinical review criteria or may purchase or license clinical review criteria from qualified vendors.

(2) A health insurance issuer shall, on request, make available its clinical review criteria to authorized government agencies, including the commissioner.

(3) Qualified health care professionals shall administer and oversee the utilization review program.

(4) A health insurance issuer shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of 33-32-211 and 33-32-212.

(5) (a) Whenever a health insurance issuer fails to adhere to the requirements of 33-32-211 or 33-32-212, as applicable, with respect to conducting a utilization review and making benefit determinations of a benefit request or claim, the covered person is considered to have exhausted the provisions of this part and may take action under subsection (5)(b).

(b) A covered person may file a request for external review in accordance with the procedures outlined in Title 33, chapter 32, part 4. In addition to filing a request, a covered person is entitled to pursue any available remedies under state or federal law if the health insurance issuer failed to provide a reasonable internal claims and appeals process designed to yield a decision on the merits of the claim.

(6) (a) Section 33-32-211 or 33-32-212 may not be considered exhausted based on a de minimis violation that does not cause and is not likely to cause prejudice or harm to the covered person, as long as the health insurance issuer demonstrates that the violation was for good cause or was due to matters beyond the control of the health insurance issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative.

(b) The exception provided in subsection (6)(a) does not apply if the violation is part of a pattern or practice of violations by the health insurance issuer.

(7) A health insurance issuer shall maintain a process to ensure that utilization reviewers apply clinical review criteria consistently in conducting utilization review.

(8) A health insurance issuer shall routinely assess the effectiveness and efficiency of its utilization review program.

(9) A health insurance issuer's data systems must be sufficient to support utilization review program activities and to generate management reports to enable the health insurance issuer to monitor and manage health care services effectively.

(10) If a health insurance issuer delegates any utilization review activities to a utilization review organization, the health insurance issuer shall maintain adequate oversight, which includes:

(a) a written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(b) evidence of formal approval of the utilization review organization's program by the health insurance issuer; and

(c) a process by which the health insurance issuer evaluates the performance of the utilization review organization.

(11) A health insurance issuer shall coordinate its utilization review program with other medical management activity conducted by the health insurance issuer, such as quality assurance, credentialing, health care provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

(12) A health insurance issuer shall provide covered persons and participating providers with access to the health insurance issuer's review staff through a toll-free number or collect-call telephone line.

(13) When conducting a utilization review, a health insurance issuer shall collect only the information necessary, including pertinent clinical information, to conduct the utilization review or make the benefit determination.

(14) (a) When conducting a utilization review, a health insurance issuer shall ensure that the review is conducted in a manner that ensures the independence and impartiality of the individuals involved in conducting the utilization review or making the benefit determination.

(b) In ensuring the independence and impartiality of individuals involved in the utilization review or benefit determination, a health insurance issuer may not make decisions regarding hiring, compensation, termination, promotion, or other similar matters based on the likelihood that the individual involved in the utilization review or benefit determination will support the denial of benefits.

History: **En. Sec. 4, Ch. 428, L. 2015.**

33-32-209. *(Effective January 1, 2026)* **Exemption for continuity of care on change in health plans.** (1) When a covered person changes health plans, a health insurance issuer or its utilization review organization shall honor a certification for health care services granted by a previous health insurance issuer or its utilization review organization for at least the first 3 months of the person's coverage under a new health plan on receiving information documenting the certification from the covered person or the person's health care provider, provided that the services are covered services under the new plan.

(2) During the time period specified in subsection (1), a utilization review organization may perform its own review to grant certification.

(3) If a change in coverage or approval criteria occurs for a previously certified health care service, the change in coverage or approval criteria does not affect a covered person who received certification for a health care service before the effective date of the change for the remainder of the authorization period or the covered person's plan year, whichever is shorter.

(4) A utilization review organization shall continue to honor a certification for health care services it has granted to a covered person when the person changes to a product offered by the same health insurance issuer, provided that the services are covered under the new plan.

History: **En. Sec. 1, Ch. 274, L. 2025.**

Compiler's Comments

Effective Date: Section 6, Ch. 274, L. 2025, provided: "[This act] is effective January 1, 2026."

33-32-210. *(Effective January 1, 2026)* **Qualifications of individuals making or reviewing adverse determinations.** (1) A health insurance issuer or its utilization review organization shall ensure that all adverse determinations pursuant to 33-32-211 or 33-32-212 are made by:

(a) a physician when the request is by or on behalf of a physician; or

(b) a health care professional licensed in the same profession as the health care professional making the request, or, in any case, by a physician.

(2) A physician or other health care professional making an adverse determination pursuant to subsection (1) must:

(a) possess a current and valid nonrestricted license; and

(b) have experience treating and managing patients with the medical condition or disease for which the health care service is being requested, or shall refer the review to a physician with the requisite specialized knowledge and experience.

(3) A health insurance issuer or its utilization review organization shall ensure that only a physician reviews a grievance as provided under 33-32-308 or 33-32-309. A physician making an adverse determination or reviewing a grievance must:

(a) possess a current and valid nonrestricted license to practice medicine; and

(b) be of a specialty that focuses on the diagnosis and treatment of the condition that is being treated.

(4) A health insurance issuer or its utilization review organization must make all adverse determinations under the clinical direction of one of the utilization review organization's medical

directors who is responsible for the oversight of the utilization review activities for covered persons in the state. A medical director used for this purpose must be a licensed physician.

(5) For the purposes of this section, "adverse determination" has the same meaning as provided in 33-32-102(1)(a) or (1)(c).

History: **En. Sec. 2, Ch. 274, L. 2025.**

Compiler's Comments

Effective Date: Section 6, Ch. 274, L. 2025, provided: "[This act] is effective January 1, 2026."

33-32-211. Procedures for standard utilization review and benefit determinations — notices. (1) A health insurance issuer shall establish written procedures and clinical review criteria for conducting standard utilization reviews and making benefit determinations on requests for benefits submitted to the health insurance issuer by covered persons or their authorized representatives. The written procedures must also include provisions for notifying covered persons or, if applicable, their authorized representatives of the health insurance issuer's determinations with respect to these requests within the timeframes specified in this section.

(2) (a) Subject to subsection (2)(c), for prospective review determinations, a health insurance issuer shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the health insurance issuer certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition. The notification must be made not later than 7 business days after the date the health insurance issuer receives the request or not later than 7 business days after the health insurance issuer receives all information under subsection (2)(d) necessary to make a determination.

(b) If the determination is an adverse determination, the health insurance issuer shall provide notification of the adverse determination in writing in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to subsection (2)(a) may be extended one time by the health insurance issuer for up to 7 business days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 7-business-day period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (2)(c) is necessary because of the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the required information necessary to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least 45 days after the date of receipt of the notice to provide the specified information.

(3) (a) If the health insurance issuer receives from a covered person or, if applicable, the covered person's authorized representative a prospective review request that fails to meet the health insurance issuer's filing procedures, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice any information regarding the proper procedures to be followed for filing a request.

(b) The notice required under subsection (3)(a) must be provided as soon as possible but not later than 3 days after the date of the failure. The health insurance issuer may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing or electronically.

(c) To qualify for the provisions of this subsection (3) related to a failed filing procedure, the communication must:

(i) have been sent by a covered person or, if applicable, the covered person's authorized representative and received by a person or an organizational unit of the health insurance issuer responsible for handling benefit matters; and

(ii) refer to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which certification is being requested.

(4) For concurrent review determinations, if a health insurance issuer has certified an ongoing course of treatment to be provided over a period of time or a specified number of treatments:

(a) any reduction or termination by the health insurance issuer during the course of treatment before the end of the period or the specified number of treatments, other than by health plan amendment or termination of the health plan, constitutes an adverse determination; and

(b) the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative of the adverse determination in accordance with subsection (8) at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's authorized representative to:

(i) file a grievance requesting a review of the adverse determination pursuant to Title 33, chapter 32, parts 3 and 4; and

(ii) obtain a determination with respect to the review of the adverse determination before the benefit is reduced or terminated.

(5) The health care service or treatment that is the subject of the adverse determination must be continued without liability to the covered person pending a determination under the internal review request made pursuant to Title 33, chapter 32, part 3.

(6) (a) For retrospective review determinations, a health insurance issuer shall make the determination no later than 30 days after the date of receiving the benefit request.

(b) If the determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with subsection (8).

(c) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to subsection (6)(a) may be extended one time by the health insurance issuer for up to 15 days if the health insurance issuer:

(i) determines that an extension is necessary due to matters beyond the health insurance issuer's control; and

(ii) notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and of the date by which the health insurance issuer expects to make a determination.

(d) If the extension under subsection (6)(c) is necessary because of the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension must:

(i) describe specifically the information required to complete the request; and

(ii) give the covered person or, if applicable, the covered person's authorized representative at least 45 days after the date of receipt of the notice to provide the specified information.

(e) A health insurance issuer is not liable for the payment of interest under 33-18-232(2) when the health insurance issuer timely complies with the requirements of this subsection (6).

(7) (a) For purposes of this section, the period within which a determination must be made begins on the date the request is received by the health insurance issuer in accordance with the health insurance issuer's procedures, established pursuant to 33-32-207, for filing a request. The date the request is received by the health insurance issuer must be counted without regard to whether all of the information necessary to make the determination accompanies the filing of the request.

(b) If the period for making the determination under this section is extended due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit the information necessary to make the determination, the period for making the determination is counted from the date on which the health insurance issuer sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:

(i) the date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information; or

(ii) the date on which the specified information was to have been submitted.

(c) If the covered person or, if applicable, the covered person's authorized representative fails to submit the information before the end of the extension period, as specified in this section, the health insurance issuer may deny the certification of the requested benefit.

(8) A notification of an adverse determination under this section must, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:

(a) information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider, and the claim amount;

(b) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information to the covered person or, if applicable, the covered person's authorized representative as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to Title 33, chapter 32, part 3, or a request for external review as outlined in Title 33, chapter 32, part 4.

(c) the specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in denying the benefit request or claim;

(d) a reference to the specific plan provision on which the determination is based;

(e) a description of any additional material or information necessary for the covered person or, if applicable, the covered person's authorized representative to complete the benefit request, including an explanation of why the material or information is necessary to complete the request;

(f) a description of the health insurance issuer's grievance procedures established pursuant to Title 33, chapter 32, part 3, including any time limits applicable to those procedures;

(g) a copy of any internal rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied on to make the adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person on request.

(h) an explanation of the scientific or clinical judgment for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request. The explanation under this subsection (8)(h) must apply the terms of the health plan to the covered person's medical circumstances.

(i) a statement explaining the availability of further assistance from the commissioner's office and the right of the covered person or, if applicable, the covered person's authorized representative to contact the commissioner's office at any time for assistance or, on completion of the health insurance issuer's grievance procedure and the external review process as provided under Title 33, chapter 32, parts 3 and 4, to file a civil suit in a court of competent jurisdiction. The statement must include contact information for the commissioner's office.

(9) (a) A health insurance issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner as required in accordance with federal regulations, including 45 CFR 147.136(e), and rules adopted pursuant to Title 33, chapter 32, part 3.

(b) To satisfy the provisions of subsection (9)(a), the health insurance issuer shall, at a minimum:

(i) provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests, claims, and appeals in any applicable non-English language;

(ii) provide, upon request, a notice in any applicable non-English language; and

(iii) include in the English version of the notice a prominently displayed statement in any applicable non-English language clearly indicating how to access the language services provided by the health insurance issuer.

(c) For purposes of this subsection (9), with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if 10% or more of the population residing in the county is literate only in the same non-English language, as determined in federal guidance.

(10) If the adverse determination is a recission, the health insurance issuer shall provide, in addition to any applicable disclosures required under this section, in a notice sent at least 30 days in advance of implementing the rescission decision:

(a) clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;

(b) an explanation of why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;

(c) the date when the advance notice period ends and the date to which the coverage is to be retroactively rescinded;

(d) notice that the covered person or, if applicable, the covered person's authorized representative may immediately file a grievance with the health insurance issuer requesting a review of the rescission; and

(e) a description of the health insurance issuer's grievance procedures, including any time limits applicable to these procedures.

(11) A health insurance issuer may provide the notices required under this section in writing or electronically.

History: **En. Sec. 5, Ch. 428, L. 2015; amd. Sec. 3, Ch. 470, L. 2019; amd. Sec. 31, Ch. 8, L. 2025.**

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 31, Ch. 8, L. 2025. Amendment effective October 1, 2025.

33-32-212. Procedures for expedited utilization review and benefit determinations. (1) With respect to urgent care requests and concurrent review urgent care requests, a health insurance issuer shall establish written procedures and clinical review criteria for receiving benefit requests from covered persons or, if applicable, their authorized representatives, for conducting an expedited utilization review and making benefit determinations, and for notifying the covered persons or their authorized representatives of the expedited utilization review and benefit determinations.

(2) (a) The procedures established under subsection (1) must include a requirement for the health insurance issuer to provide that, in the case of a failure by a covered person or, if applicable, the covered person's authorized representative to follow the health insurance issuer's procedures for filing an urgent care request, the covered person or the covered person's authorized representative must be notified of the failure and the proper procedures to be followed for filing the request.

(b) The notice required under subsection (2)(a):

(i) must be provided to the covered person or, if applicable, the covered person's authorized representative not later than 24 hours after receipt of the request; and

(ii) may be made orally, unless the covered person or, if applicable, the covered person's authorized representative requests the notice in writing or electronically.

(c) To qualify for the provisions of this subsection (2) related to a failed filing procedure, the communication must:

(i) be sent by a covered person or, if applicable, the covered person's authorized representative and received by a person or organizational unit of the health insurance issuer responsible for handling benefit matters; and

(ii) contain a reference to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which approval is being requested.

(3) (a) For an urgent care request, unless the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health

insurance issuer to determine whether or to what extent the benefits requested are covered benefits or payable under the health insurance issuer's health plan, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative as soon as possible, taking into account the medical condition of the covered person, but no later than 48 hours after the receipt of the request by the health insurance issuer.

(b) With respect to the request, the health insurance issuer shall state in the notification whether or not the determination is an adverse determination. If the health insurance issuer's determination is an adverse determination, the notice must comply with the provisions of subsection (7).

(4) (a) If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health insurance issuer to make a determination, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing or electronically of this failure and identify what specific information is needed. This notification must be made as soon as possible but not later than 24 hours after receipt of the request.

(b) The health insurance issuer shall, taking into account the circumstances, provide the covered person or, if applicable, the covered person's authorized representative with a reasonable period of time to submit the necessary information. The reasonable period may not end less than 48 hours after the health insurance issuer notifies the covered person or, if applicable, the covered person's authorized representative of the failure to submit sufficient information as provided in subsection (4)(a).

(c) A health insurance issuer shall, in cases in which more information is required as provided in subsection (4)(a), notify the covered person or, if applicable, the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible but not later than 24 hours after the earlier of:

(i) the health insurance issuer's receipt of the requested information; or

(ii) the end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested information.

(d) If the covered person or, if applicable, the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in subsection (4)(b), the health insurance issuer may deny the certification of the requested benefit.

(e) If the health insurance issuer's determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination in accordance with subsection (7).

(5) (a) For concurrent review urgent care requests involving a request by the covered person or, if applicable, the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the health insurance issuer shall make a determination with respect to the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but not later than 24 hours after the health insurance issuer's receipt of the request.

(b) If the health insurance issuer's determination is an adverse determination, the health insurance issuer shall provide notice of the adverse determination as provided in subsection (7).

(6) For the purposes of this section, the time period within which a determination must be made begins on the date and at the time the request is filed with the health insurance issuer in accordance with the health insurance issuer's procedures established pursuant to 33-32-207 for filing a request. The date and time the request is received by the health insurance issuer must be counted without regard to whether all of the information necessary to make the determination accompanies the filing of the request.

(7) A notification of an adverse determination under this section must, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:

(a) information sufficient to identify the benefit request or claim involved and, if applicable, the date of service, the health care provider, and the claim amount;

(b) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to Title 33, chapter 32, part 3, or a request for external review as outlined in Title 33, chapter 32, part 4.

(c) the specific rationale behind the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in denying the benefit request or claim;

(d) a reference to the specific plan provisions on which the determination is based;

(e) a description of any additional material or information necessary for the covered person or, if applicable, the covered person's authorized representative to complete the request, including an explanation of why the material or information is necessary to complete the request;

(f) a description of the health insurance issuer's internal grievance procedures established pursuant to Title 33, chapter 32, part 3, including any time limits applicable to those procedures;

(g) a description of the health insurance issuer's expedited grievance procedures established pursuant to Title 33, chapter 32, part 3, including any time limits applicable to those procedures;

(h) a copy of any internal rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied on to make the adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person on request.

(i) an explanation of the scientific or clinical judgment for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request. The explanation under this subsection (7)(i) must apply the terms of the health plan to the covered person's medical circumstances.

(j) instructions for requesting any of the following that are applicable:

(i) a copy of the rule, guideline, protocol, or other similar criteria relied on in making the adverse determination in accordance with subsection (7)(h); or

(ii) the written statement of the scientific or clinical rationale for the adverse determination in accordance with subsection (7)(i); and

(k) a statement explaining the availability of further assistance from the commissioner's office and the right of the covered person or, if applicable, the covered person's authorized representative to contact the commissioner's office at any time for assistance or, on completion of the health insurance issuer's grievance procedure process as provided under Title 33, chapter 32, part 3, to file a civil suit in a court of competent jurisdiction. The statement must include contact information for the commissioner's office.

(8) A health insurance issuer shall provide the notice required under this section in the manner provided in 33-32-211(9).

(9) (a) A health insurance issuer may provide the notice required under this section orally, in writing, or electronically.

(b) If notice of the adverse determination is provided orally, the health insurance issuer shall provide written or electronic notice of the adverse determination within 3 days following the oral notification.

History: **En. Sec. 6, Ch. 428, L. 2015; amd. Sec. 4, Ch. 470, L. 2019.**

33-32-213 and 33-32-214 reserved.

33-32-215. Emergency services. (1) When conducting a utilization review or making a benefit determination for emergency services, a health insurance issuer that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.

(2) A health insurance issuer shall cover emergency services that screen and stabilize a covered person:

(a) without the need for prior authorization of the emergency services if a prudent lay person would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;

(b) without regard to whether the health care provider furnishing the services is a participating provider with respect to the emergency services;

(c) if the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;

(d) if the emergency services are provided out-of-network, by complying with the cost-sharing requirements in subsection (4); and

(e) without regard to any other term or condition of coverage, other than:

(i) the exclusion of or coordination of benefits;

(ii) an affiliation or waiting period as permitted under 42 U.S.C. 300gg-19a; or

(iii) cost-sharing, as provided in subsection (4)(a).

(3) For in-network emergency services, coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles.

(4) (a) Only in-network cost sharing amounts may be imposed on out-of-network emergency services.

(b) A health insurance issuer complies with the requirements of this section by paying for emergency services provided by an out-of-network provider in an amount not less than the greatest of the following and taking into account exceptions in subsections (4)(c) and (4)(d):

(i) the amount negotiated with in-network providers for emergency services, excluding any in-network cost-sharing imposed with respect to the covered person;

(ii) the amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

(iii) the amount that would be paid under medicare for the emergency services, excluding any in-network cost-sharing requirements.

(c) For capitated or other health plans that do not have a negotiated charge for each service for in-network providers, subsection (4)(b)(i) does not apply.

(d) If a health plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subsection (4)(b)(i) is the median of those negotiated amounts.

(5) A health insurance issuer shall allow a covered person, the person's authorized representative, and the person's health care provider at least 24 hours following an emergency admission or the provision of emergency services to notify the health insurance issuer of the admission or provision of emergency services. If the admission or the emergency services occur on a holiday or weekend, a health insurance issuer shall allow notification no later than by the next business day following the admission or provision of emergency services.

(6) If prior authorization is required for a postevaluation or poststabilization services review, a health insurance issuer shall provide access to a designated representative 24 hours a day, 7 days a week, to facilitate the review.

History: En. Sec. 7, Ch. 428, L. 2015; amd. Sec. 5, Ch. 470, L. 2019; amd. Sec. 33, Ch. 157, L. 2023.

33-32-216. Confidentiality. A health insurance issuer and its designee shall comply with all applicable state and federal laws establishing confidentiality and reporting requirements with regard to its utilization review program, including the provisions of Title 33, chapter 19, and 45 CFR, parts 160 and 164.

History: En. Sec. 8, Ch. 428, L. 2015.

33-32-217. Disclosure. (1) In the certificate of coverage and member handbook provided to covered persons, a health insurance issuer shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of the rights and responsibilities of covered persons with respect to those procedures.

(2) In the outline of coverage provided to covered persons, a health insurance issuer shall include a statement indicating the section of the member handbook containing the information required in subsection (1).

(3) A health insurance issuer shall print on its membership cards a toll-free telephone number to call for utilization review and benefit determinations.

History: En. Sec. 9, Ch. 428, L. 2015.

33-32-218 through 33-32-220 reserved.

33-32-221. Prior authorization requirements. (1) A health insurance issuer or an entity that it contracts with to perform prior authorization on its behalf may not perform prior authorization on benefits for:

(a) any generic prescription drug that is not included in subsections (1)(d) through (1)(g) and that is not listed within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32, after a covered person has been prescribed the covered drug at the same quantity without interruption for 6 months;

(b) any prescription drug or drugs, generic or brand name, on the grounds of therapeutic duplication for the same drug if the covered person has already been subject to prior authorization on the grounds of therapeutic duplication for the same dosage of the prescription drug or drugs and coverage of the prescription drug or drugs was approved;

(c) any prescription drug, generic or brand name, solely because the dosage of the medication for the covered person has been adjusted by the prescriber of the prescription drug, as long as the dosage is within the dosage approved by the food and drug administration or is consistent with clinical dosing for the medication;

(d) any prescription drug, generic or brand name, that is a long-acting injectable antipsychotic;

(e) any formulary oral or inhaled nonbiologic generic prescription drug that is not listed as a specialty tier drug by medicare Part D, or within any of the schedules of controlled substances found at 21 CFR 1308.11 through 21 CFR 1308.15 or the schedules of controlled substances found in Title 50, chapter 32;

(f) any formulary nonspecialty inhaled prescription drug, generic or brand name, for the treatment of asthma, chronic obstructive pulmonary disease, or chronic lung disease;

(g) formulary generic or brand name insulin for patients diagnosed with diabetes;

(h) any prescription drug, generic or brand name, prescribed for treatment of a substance use disorder, provided that the drug is approved by the U.S. food and drug administration for treatment of substance use disorder and the prescription does not exceed the U.S. food and drug administration labeled dosages; or

(i) any prescription drug, generic or brand name, that is designated as in shortage pursuant to subsection (4).

(2) Any adverse determination for a prescription drug made during prior authorization by a health insurance issuer or an entity that it contracts with to perform prior authorization on its behalf must be made by a physician whose specialty focuses on the diagnosis and treatment of the condition for which the prescription drug was prescribed to treat, provided that prior authorization that does not result in an adverse determination does not require the involvement of a physician on the part of a health insurance issuer or an entity that it contracts with to perform prior authorization on its behalf.

(3) If the health insurance issuer or an entity that it contracts with to perform prior authorization on its behalf makes an adverse determination for a prescription drug during prior authorization, it shall provide a written adverse determination notice that includes a list of reasonable therapeutic alternatives that are covered by the insurer's formulary.

(4) (a) For the purposes of subsection (1)(i), the list of prescription drugs within the therapeutic category of psychiatry that are in shortage on April 1, July 1, October 1, or January 1 must be determined directly from the official shortage list published by the United States food and drug administration on those dates. The quarterly static list remains in effect until the next quarterly date.

(b) A manufacturer of a prescription drug subject to subsection (1)(i) may not engage in predatory pricing or marketing related to any shortage described in this section. A violation of this subsection (4)(b) is subject to enforcement and penalty under Title 30, chapter 14, part 1.

History: En. Sec. 1, Ch. 680, L. 2023; amd. Sec. 1, Ch. 121, L. 2025; amd. Sec. 1, Ch. 571, L. 2025; amd. Sec. 3, Ch. 611, L. 2025.

Compiler's Comments

2025 Amendments — Composite Section — Coordination: See 2025 Session Law for amendment made by sec. 1, Ch. 121, L. 2025. Amendment effective October 1, 2025.

See 2025 Session Law for amendment made by sec. 1, Ch. 571, L. 2025. Amendment effective October 1, 2025.

See 2025 Session Law for amendment made by sec. 3, Ch. 611, L. 2025. Amendment effective October 1, 2025.

The amendment to this section made by sec. 3, Ch. 612, L. 2025, was rendered void by sec. 5, Ch. 612, L. 2025, a coordination section.

33-32-222. Prohibition on prior authorization requirements for prescriptions written at discharge from inpatient care. (1) A prescription written for an inpatient and patient under observation at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and must be immediately approved for not less than 3 days, provided that:

(a) the cost of the medication does not exceed $5,000 a day; and

(b) the physician shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge.

(2) Approval beyond 3 days is subject to prior authorization review under 33-32-212.

History: En. Sec. 2, Ch. 577, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

Applicability: Section 7, Ch. 577, L. 2025, provided: "[This act] applies to policies or agreements to provide coverage for health care services issued or renewed on or after [the effective date of this act]." Effective October 1, 2025.

33-32-223. Required method of accepting prior authorization requests. (1) A health insurance issuer or utilization review organization shall accept and respond electronically to prior authorization requests from a health care provider submitted through a secure electronic transmission as determined by the health insurance issuer or utilization review organization.

(2) If a prior authorization for a prescription drug is submitted electronically using the national council for prescription drug program's standard for electronic prior authorization transactions, then the health insurance issuer or utilization review organization shall accept and respond to the prior authorization request using the same standard for electronic prior authorization transactions.

(3) This section does not require a health care professional to submit prior authorization requests electronically.

History: En. Sec. 4, Ch. 577, L. 2025.

Compiler's Comments

Effective Date: This section is effective October 1, 2025.

Applicability: Section 7, Ch. 577, L. 2025, provided: "[This act] applies to policies or agreements to provide coverage for health care services issued or renewed on or after [the effective date of this act]." Effective October 1, 2025.

Part 3
Grievance Procedures

33-32-301. Short title. The provisions of Title 33, chapter 32, parts 3 and 4, may be cited as the "Health Insurance Issuer Grievance Procedures and External Review Act".

History: En. Sec. 10, Ch. 428, L. 2015.

33-32-302. Applicability and scope. (1) Except as provided in subsection (2), the provisions of Title 33, chapter 32, parts 3 and 4, apply to all health insurance issuers.

(2) The provisions of Title 33, chapter 32, parts 3 and 4, do not apply to:

(a) a policy or certificate that provides coverage only for a specified disease or specified accident, accident-only coverage, credit insurance as described in 33-1-206, dental, disability income, or hospital indemnity insurance, long-term care insurance as defined in 33-22-1107, vision care insurance, or any other limited supplemental benefit;

(b) a medicare supplement policy as defined in 33-22-903;

(c) coverage under a plan through medicare or medicaid or any coverage issued under Title 10, chapter 55, of the United States Code and any coverage issued as supplemental to that coverage; or

(d) any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket basis or an individual basis.

History: **En. Sec. 11, Ch. 428, L. 2015.**

33-32-303. Purpose. The purpose of this part is to provide standards for the establishment and maintenance of procedures by health insurance issuers to ensure that covered persons have the opportunity for the appropriate resolution of grievances.

History: **En. Sec. 12, Ch. 428, L. 2015.**

33-32-304 and 33-32-305 reserved.

33-32-306. Grievance reporting and recordkeeping requirements — definition. (1) (a) A health insurance issuer shall maintain within a register all written records that document grievances received during a calendar year, including the notices and claims associated with the grievances.

(b) For the purposes of this section, "register" means the written record of grievances received by a health insurance issuer that includes the notices and claims associated with the grievances as required by this section.

(2) Retention of the records in the register must be as provided in subsection (6), except that a health insurance issuer shall maintain for at least 6 years those records specified by the commissioner by rule.

(3) A health insurance issuer shall:

(a) maintain the records in a manner that is reasonably clear and accessible to the commissioner; and

(b) make the records available for examination, on request, by covered persons, the commissioner, and any appropriate federal oversight agency.

(4) A request for a review of a grievance involving an adverse determination must be processed in compliance with 33-32-308 and must be included in the register.

(5) For each grievance, the register must contain, at a minimum, the following information:

(a) a general description of the reason for the grievance;

(b) the date received;

(c) the date of each review or, if applicable, review meeting;

(d) a report on the resolution of the grievance, if applicable;

(e) the date of the resolution, if applicable; and

(f) the name of the covered person for whom the grievance was filed.

(6) Subject to the provisions of subsection (2), a health insurance issuer shall retain the register compiled in a calendar year for 3 years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year, whichever is longer.

(7) (a) At least annually, a health insurance issuer shall submit to the commissioner a report in the format specified by the commissioner.

(b) The report must include for each type of health plan offered by the health insurance issuer:

(i) the certificate of compliance required by 33-32-307(4)(b);

(ii) the number of covered persons;

(iii) the total number of grievances;

(iv) the number of grievances resolved, if applicable, and their resolution;

(v) the number of grievances referred to an alternative dispute resolution procedure or resulting in litigation; and

(vi) a synopsis of actions taken or being taken to correct problems that have been identified.

History: **En. Sec. 13, Ch. 428, L. 2015; amd. Sec. 11, Ch. 62, L. 2019.**

33-32-307. Grievance review procedures. (1) Except as specified in 33-32-309, a health insurance issuer shall use written procedures for receiving and resolving grievances from covered persons as provided in 33-32-308.

(2) (a) Whenever a health insurance issuer fails to adhere to the requirements of 33-32-308 or 33-32-309, as applicable, with respect to receiving and resolving grievances involving an adverse determination or waives the review of the grievance, the covered person is considered to have exhausted the provisions of this part and may take action under subsection (2)(b).

(b) (i) A covered person may file a request for external review in accordance with the procedures outlined in Title 33, chapter 32, part 4.

(ii) In addition to filing a request under subsection (2)(b)(i), a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health insurance issuer failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(3) (a) The provisions of 33-32-308 or 33-32-309 may not be considered exhausted based on a de minimis violation that does not cause and is not likely to cause prejudice or harm to the covered person as long as the health insurance issuer demonstrates that the violation was for good cause or due to matters beyond the control of the health insurance issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative.

(b) The exception provided in subsection (3)(a) does not apply if the violation is part of a pattern or a practice of violations by the health insurance issuer.

(4) A health insurance issuer shall file with the commissioner:

(a) a copy of the procedures required under subsection (1), including all forms used to process requests made pursuant to 33-32-308. Any subsequent material modifications to the documents must also be filed.

(b) as part of the annual report required by 33-32-306(7), a certificate of compliance stating that the health insurance issuer has established and maintains for each of its health plans a set of grievance procedures that fully comply with the provisions of this part; and

(c) a description of the grievance procedures required under this section, which must be included in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons. The grievance procedure documents must include a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement must include the telephone number and address of the commissioner's office.

(5) The commissioner may disapprove a filing received in accordance with subsection (4) if the filing fails to comply with this part or applicable federal regulations.

History: **En. Sec. 14, Ch. 428, L. 2015.**

33-32-308. Grievances involving adverse determination. (1) Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to Title 33, chapter 32, part 2, a covered person or, if applicable, the covered person's authorized representative may file a grievance with the health insurance issuer requesting a review of the adverse determination.

(2) The health insurance issuer shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address, and telephone number of a person or organizational unit designated to coordinate the review on behalf of the health insurance issuer.

(3) (a) In providing for a review under this section, the health insurance issuer shall ensure that the review meets the requirements of this section and is conducted in a manner that ensures the independence and impartiality of the individuals involved in making the review decision.

(b) To ensure the independence and impartiality of the individuals involved in making the review decision, the health insurance issuer may not make hiring, compensation, termination, promotion, or other similar decisions related to any of those individuals based on the likelihood that the individual will support the denial of benefits.

(4) (a) In the case of an adverse determination involving utilization review, the health insurance issuer shall designate one or more appropriate physicians or health care professionals of the same licensure to review the adverse determination. A physician or health care professional of the same licensure may not have been involved in the initial adverse determination.

(b) In designating an appropriate physician or health care professional of the same licensure pursuant to subsection (4)(a), the health insurance issuer shall ensure that if more than one physician or health care professional of the same licensure is involved in the review, a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

(5) In conducting a review under subsection (4), each physician or health care professional of the same licensure shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or, if applicable, the covered person's authorized representative without regard to whether the information was submitted or considered in making the initial adverse determination.

(6) (a) A covered person does not have the right to attend or to have a representative in attendance at the review, but the covered person or, if applicable, the covered person's authorized representative is entitled to:

(i) submit written comments, documents, records, and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

(ii) receive from the health insurance issuer, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the covered person's request for benefits.

(b) For the purposes of subsections (6)(a) and (11)(f)(iii), the term "relevant" in relation to a document, record, or other information related to a covered person's request for benefits means the document, record, or other information:

(i) was relied on in making the benefit determination;

(ii) was submitted, considered, or generated in the course of making the adverse determination without regard to whether the document, record, or other information was relied on in making the benefit determination;

(iii) was used to demonstrate that in making the benefit determination, the health insurance issuer or its designated representatives consistently applied to the covered person the required administrative procedures and safeguards used for other similarly situated covered persons; or

(iv) constituted a statement of policy or guidance with respect to the health plan concerning the denied health care service or treatment for the covered person's diagnosis without regard to whether the advice or statement was relied on in making the benefit determination.

(7) The health insurance issuer shall disclose the provisions of subsection (6) to the covered person or, if applicable, the covered person's authorized representative, in writing:

(a) in the notice of adverse determination that is the subject of the grievance; or

(b) in a separate notice sent within 3 working days after the date of receipt of the grievance.

(8) For the purposes of calculating the time period within which a determination must be made and noticed under subsection (9), the time period begins on the date the request for a grievance review is filed with the health insurance issuer in accordance with the health insurance issuer's procedures for filing requests established pursuant to 33-32-307 without regard to whether all of the information necessary to make the determination accompanies the filing.

(9) (a) A health insurance issuer shall notify and issue a decision with respect to a grievance requesting a review of an adverse determination involving a prospective review or a retrospective review request. The notification must be in writing or sent electronically to the covered person or, if applicable, the covered person's authorized representative.

(b) The health insurance issuer shall issue a decision and send notification as provided in this section within a reasonable period of time that is appropriate considering the covered person's medical condition but no later than 30 days in the case of a prospective review or 60 days in the case of a retrospective review after the date on which the health insurance issuer received the grievance request for the review made pursuant to subsection (1).

(10) Prior to issuing a decision or final adverse determination in accordance with the timeframe provided in subsection (9) and sufficiently in advance of the required date for a decision or final adverse determination to allow the covered person or, if applicable, the covered person's authorized representative a reasonable opportunity to respond prior to the date of the decision or final adverse determination, the health insurance issuer shall provide free of charge to the covered person or, if applicable, the covered person's authorized representative:

(a) any new or additional relevant evidence relied on or generated by the health insurance issuer or at the health insurance issuer's direction in connection with the grievance; and

(b) in relation to the issuance and notice of a final adverse determination based on new or additional rationale, the new or additional rationale.

(11) The decision issued pursuant to subsection (9) must specify in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative the following:

(a) the titles and qualifying credentials of each physician or health care professional of the same licensure participating in the review process;

(b) information sufficient to identify the claim involved with respect to the grievance, including, as applicable, the date of service, the health care provider, and the claim amount;

(c) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to this part or a request for external review as outlined in Title 33, chapter 32, part 4.

(d) a statement from the physicians or health care professionals of the same licensure participating in the review of their understanding of the covered person's grievance;

(e) the decision of the physicians or health care professionals of the same licensure conducting the review, provided in clear terms, and the contract basis or medical rationale on which the decision was based, provided in sufficient detail for the covered person or, if applicable, the covered person's authorized representative to respond further to the health insurance issuer's position;

(f) a reference to the evidence or documentation used as the basis for the decision. The information required under this subsection (11)(f) must also include for a review decision issued pursuant to subsection (9) that upholds an adverse determination:

(i) all specific reasons that uphold the final internal adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in reaching the denial;

(ii) the reference to the specific plan provisions on which the adverse determination is based;

(iii) a statement that the covered person is entitled to receive, on request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the covered person's benefit request;

(iv) a copy of any specific rule, guideline, protocol, or other similar criteria that the health insurance issuer may have relied on to make the final adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the final adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person on request;

(v) an explanation of the scientific or clinical judgment used for making the adverse determination if the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. The explanation must apply the terms of the health plan to the covered person's medical circumstances. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request.

(vi) instructions for requesting all of the following that are applicable:

(A) a copy of the rule, guideline, protocol, or other similar criteria relied on in making the final adverse determination in accordance with subsection (11)(f)(iv); or

(B) the written statement of the scientific or clinical rationale for the final adverse determination in accordance with subsection (11)(f)(v);

(vii) a statement, if applicable, indicating:

(A) a description of the procedures for obtaining an independent external review of the final adverse determination pursuant to Title 33, chapter 32, part 4; and

(B) the covered person's right to bring a civil action in a court of competent jurisdiction;

(viii) the following statement, if applicable:

"You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance commissioner."

(ix) notice of the covered person's right to contact the commissioner's office for further assistance on any claim, grievance, or appeal at any time, including the telephone number and address of the commissioner's office. The notice under this subsection (11)(f)(ix) must be provided in accordance with federal regulations and as provided in 33-32-211(9).

History: En. Sec. 15, Ch. 428, L. 2015.

33-32-309. Expedited review of grievance involving adverse determination. (1) A health insurance issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

(2) A health insurance issuer shall provide an expedited review of a grievance involving an adverse determination with respect to a concurrent review of an urgent care request involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility. The procedures in subsection (1) must also specify the process for the concurrent review of urgent care requests under this subsection (2).

(3) The procedures under this section must provide that a covered person or, if applicable, the covered person's authorized representative may request an expedited review orally, in writing, or electronically.

(4) On receipt of a request for an expedited review, a health insurance issuer shall appoint one or more physicians or health care professionals of the same licensure to review the adverse determination. An appointed physician or health care professional of the same licensure may not have been involved in making the initial adverse determination.

(5) In an expedited review, all necessary information, including the health insurance issuer's decision, must be transmitted between the health insurance issuer and the covered person or, if applicable, the covered person's authorized representative in the most expeditious method available, whether by telephone, facsimile, or other method.

(6) (a) The timeframe for making a decision under an expedited review and notification, as provided in subsection (8), must be as expeditious as the covered person's medical condition requires but may take no more than 72 hours after the receipt of the request for the expedited review.

(b) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the health insurance issuer shall continue the health care service or treatment without liability to the covered person until the covered person has been notified of the determination.

(7) For purposes of calculating the timeframe within which a decision is required to be made under subsection (6), the time period within which the decision must be made begins on the date the request is filed with the health insurance issuer in accordance with the health insurance issuer's procedures for filing requests established under 33-32-307 without regard to whether all of the information necessary to make the determination accompanies the filing.

(8) A notification of a decision under this section must be in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative and, if necessary, meet the requirements of subsection (9). The notification must include:

(a) the titles and qualifying credentials of each physician or health care professional of the same licensure participating in the expedited review process;

(b) information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, and, if applicable, the claim amount;

(c) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for external review as outlined in Title 33, chapter 32, part 4.

(d) a statement from the physicians or health care professionals of the same licensure participating in the review of their understanding of the covered person's grievance;

(e) a description in clear terms of the decision of the physicians or health care professionals of the same licensure and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health insurance issuer's position;

(f) a reference to the evidence or documentation used as the basis for the decision. If the decision involves an adverse determination, the notice must provide:

(i) all specific reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health insurance issuer's standard, if any, that was used in reaching the denial;

(ii) the reference to the specific plan provisions on which the determination is based;

(iii) if the adverse determination is based on incomplete documentation, a description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(iv) a copy of any internal rule, guideline, protocol, or other similar criteria if relied on by the health insurance issuer to make the adverse determination. Alternatively, the health insurance issuer may provide a statement that a specific rule, guideline, protocol, or other similar criteria was relied on to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criteria will be provided free of charge to the covered person on request.

(v) an explanation of the scientific or clinical judgment used for making the adverse determination if the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit. The explanation must apply the terms of the health plan to the covered person's medical circumstances. Alternatively, the health insurance issuer may provide a statement that an explanation will be provided to the covered person free of charge on request.

(vi) instructions for requesting any of the following that are applicable:

(A) a copy of the rule, guideline, protocol, or other similar criteria relied on in making the adverse determination in accordance with subsection (8)(f)(iv); or

(B) the written statement of the scientific or clinical rationale for the adverse determination in accordance with subsection (8)(f)(v);

(vii) a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to Title 33, chapter 32, part 4;

(viii) the following statement, if applicable:

"You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance commissioner."

(ix) a statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction; and

(x) a notice of the covered person's right to contact the commissioner's office for assistance at any time, including the telephone number and address of the commissioner's office.

(9) The notice under subsection (8)(f) must be provided in accordance with federal regulations and as provided in 33-32-211(9).

(10) (a) A health insurance issuer may provide the notice required under this section orally, in writing, or electronically.

(b) If notice of the adverse determination is provided orally, the health insurance issuer shall provide written or electronic notice of the adverse determination within 3 days after the oral notification.

History: **En. Sec. 16, Ch. 428, L. 2015.**

Part 4
External Review

33-32-401. Purpose. The purpose of this part is to provide uniform standards for the establishment and maintenance of external review procedures to ensure that covered persons have the opportunity for an independent review of an adverse determination or a final adverse determination.

History: **En. Sec. 17, Ch. 428, L. 2015.**

33-32-402. Definitions for external review. For the purposes of this part, the following definitions apply:

(1) "Adverse determination" means a determination by a health insurance issuer or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a covered benefit has been reviewed and, based on the information provided, does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness and as a result the requested service or payment for the service has been denied, reduced, or terminated.

(2) "Best evidence" means evidence based on:

(a) randomized clinical trials;

(b) a cohort study or case-control study if randomized clinical trials are not available;

(c) a case series if information as provided in subsection (2)(a) or (2)(b) is unavailable; or

(d) an expert opinion if information as provided in subsection (2)(a), (2)(b), or (2)(c) is unavailable.

(3) "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

(4) "Case series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(5) "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.

(6) "Disclose" means to release, transfer, or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(7) "Evidence-based standard" means the conscientious, explicit, and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(8) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

(9) "Health information" means information or data, whether oral or recorded in any form or medium, including personal facts or information about events or relationships that relate to:

(a) the past, present, or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family;

(b) the provision of health care services to a covered person; or

(c) payment for the provision of health care services to a covered person.

(10) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.

(11) "Medical or scientific evidence" means evidence found in the following sources:

(a) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(b) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the national institutes of health's library of medicine for indexing in Index Medicus and Excerpta Medica, published by the Reed Elsevier group;

(c) medical journals recognized by the secretary of health and human services under 42 U.S.C. 1395x(t)(2)(B) of the federal Social Security Act;

(d) the following standard reference compendia:

(i) the American Hospital Formulary Service Drug Information;

(ii) Drug Facts and Comparisons;

(iii) the American Dental Association Guide to Dental Therapeutics; and

(iv) the United States Pharmacopeia;

(e) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(i) the federal agency for healthcare research and quality;

(ii) the national institutes of health;

(iii) the national cancer institute;

(iv) the national academy of sciences;

(v) the centers for medicare and medicaid services;

(vi) the food and drug administration; and

(vii) any national board recognized by the national institutes of health for the purpose of evaluating the medical value of health care services; or

(f) any other medical or scientific evidence that is comparable to the sources listed in subsection (11)(d) or (11)(e).

(12) "NAIC" means the national association of insurance commissioners.

(13) "Protected health information" means health information:

(a) that identifies an individual who is the subject of the information; or

(b) with respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(14) "Randomized clinical trial" means a controlled, prospective study of patients who have been assigned at random to an experimental group or a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention. The term includes a study of the groups for variables and anticipated outcomes over time.

History: En. Sec. 18, Ch. 428, L. 2015.

33-32-403. Notice of right to external review. (1) A health insurance issuer shall:

(a) notify the covered person or, if applicable, the covered person's authorized representative in writing of the covered person's right to request an external review pursuant to 33-32-410, 33-32-411, or 33-32-412; and

(b) include the appropriate statements and information described in subsection (4) at the same time that the health insurance issuer sends written notice of:

(i) an adverse determination upon completion of the health insurance issuer's utilization review process described in Title 33, chapter 32, part 2; and

(ii) a final adverse determination.

(2) The health insurance issuer shall include in the written notice required under subsection (1) the following, or substantially equivalent, language:

"We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or level of effectiveness of the health care service or treatment you requested. You may exercise this right by submitting a request for external review to us [insert address and telephone number of the unit of the health insurance issuer that administers the external review program]."

(3) (a) The commissioner may prescribe the form and content of the notice required under this section.

(b) The notice must also include the following information:

(i) information sufficient to identify the claim involved, including the date of service, the health care provider, and, if applicable, the claim amount; and

(ii) a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. On receiving a request for a diagnosis or treatment code, the health insurance issuer shall provide the information as soon as practicable. A health insurance issuer may not consider a request for the diagnosis code and treatment information, in itself, to be a request for an external review as outlined in this part.

(4) The health insurance issuer shall include in the notice required under subsection (1) a statement that:

(a) for a notice related to an adverse determination:

(i) the covered person or, if applicable, the covered person's authorized representative may file a grievance under the health insurance issuer's internal grievance process provided for in 33-32-308;

(ii) if the health insurance issuer has not issued a written decision to the covered person or the covered person's authorized representative within the time period provided in 33-32-308 or 33-32-309, as applicable, after the date the covered person or the covered person's authorized representative files the grievance with the health insurance issuer and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for external review pursuant to 33-32-404. Under those conditions, the covered person or the covered person's authorized representative is considered to have exhausted the health insurance issuer's internal grievance process for the purposes of 33-32-307.

(iii) the covered person or the covered person's authorized representative may file a request for an expedited external review to be conducted pursuant to 33-32-411 or 33-32-412, as applicable, under the following circumstances:

(A) a review under 33-32-411 may be requested if the covered person has a medical condition with regard to which the timeframe for completion of an expedited grievance review of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(B) a review under 33-32-412 may be requested if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated. The health care provider's certification must be submitted at the same time that the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination. However, the independent review organization assigned to conduct the expedited external review is responsible for determining whether the covered person is required to complete the expedited review of the grievance before the expedited external review can begin.

(iv) informs the covered person or the covered person's authorized representative of the other exhaustion methods listed in 33-32-405;

(b) for a notice related to a final adverse determination, the covered person or the covered person's authorized representative may file a request for:

(i) an expedited external review under 33-32-411 if the covered person has a medical condition for which the timeframe for completion of a standard external review under 33-32-410 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(ii) an expedited external review under 33-32-411 if the covered person has received emergency services and has not been discharged from a facility and the request concerns an admission, the availability of care, a continued stay, or a health care service for which the covered person received emergency services;

(iii) a standard external review under 33-32-412 if the denial of coverage was based on a determination that the recommended or requested health care service or treatment is experimental or investigational; or

(iv) an expedited external review under 33-32-412 if a covered person to which subsection (4)(b)(iii) applies attaches a written certification from the covered person's treating health care provider that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(5) In addition to the information to be provided in subsections (1) and (2), the health insurance issuer shall:

(a) include a description of both the standard and the expedited external review procedures as required by the disclosure requirements under 33-32-423, highlighting the provisions in the external review procedures that give the covered person or, if applicable, the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review; and

(b) state that the commissioner's office is available to assist covered persons with the external review process. This statement must include the commissioner's contact information.

(6) Among the forms provided under this section, the health insurance issuer shall include an authorization form or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508 and 33-19-206, by which the covered person, for purposes of conducting an external review under this part, authorizes the health insurance issuer and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person for the purposes of the external review.

History: **En. Sec. 19, Ch. 428, L. 2015; amd. Sec. 40, Ch. 151, L. 2017.**

33-32-404. Request for external review. (1) Except for a request for an expedited external review provided for in 33-32-411, all requests for an external review must be made in writing to the health insurance issuer.

(2) A request for expedited external review may be made by telephone or in another expeditious manner.

(3) The commissioner may prescribe the form and content of external review requests submitted under this section.

(4) A covered person or, if applicable, the covered person's authorized representative may make a request for an external review of an adverse determination or a final adverse determination.

History: **En. Sec. 20, Ch. 428, L. 2015.**

33-32-405. Exhaustion of internal grievance process. (1) Except as provided in subsections (2), (4), (5), and (6), a request for an external review pursuant to 33-32-410, 33-32-411, or 33-32-412 may not be made until the covered person has exhausted the health insurance issuer's internal grievance process provided for in Title 33, chapter 32, part 3.

(2) For the purposes of this section, a covered person is considered to have exhausted the health insurance issuer's internal grievance process if the covered person or, if applicable, the covered person's authorized representative:

(a) has filed a grievance involving an adverse determination pursuant to 33-32-308; and

(b) has not received a written decision on the grievance from the health insurance issuer within the time period provided in 33-32-308 or 33-32-309, as applicable, from the date the covered person or the covered person's authorized representative filed the grievance with the health insurance issuer except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay.

(3) Except as provided in subsection (2), a covered person or, if applicable, the covered person's authorized representative may not request an external review of an adverse determination involving a retrospective review determination made pursuant to Title 33, chapter 32, part 3, until the covered person has exhausted the health insurance issuer's internal grievance process.

(4) (a) At the same time a covered person or, if applicable, the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination under 33-32-308, the covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:

(i) under 33-32-411 if the covered person has a medical condition for which the timeframe for completion of an expedited review of the grievance involving an adverse determination provided for in 33-32-308 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) under 33-32-412 if the adverse determination involves a denial of coverage based on a determination that:

(A) the recommended or requested health care service or treatment is experimental or investigational; and

(B) the covered person's treating health care provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

(b) On receipt of a request for an expedited external review under subsection (4)(a), the independent review organization conducting the external review as provided under 33-32-411 or 33-32-412 shall determine whether the covered person must be required to complete the expedited review process for grievances provided for in 33-32-309 before an expedited external review can be conducted.

(c) Upon a determination made pursuant to subsection (4)(b) that the covered person must first be required to complete the expedited grievance review process provided for in 33-32-309, the independent review organization shall immediately notify the covered person or, if applicable, the covered person's authorized representative of this determination. The notification also must state that the independent review organization will not proceed with the expedited external review under 33-32-411 until:

(i) the expedited grievance review process under 33-32-309 is completed; and

(ii) the covered person's grievance at the completion of the expedited grievance review process remains unresolved.

(5) A request for an external review of an adverse determination may be made before the covered person has exhausted the health insurance issuer's internal grievance procedures as provided in 33-32-307 whenever the health insurance issuer agrees to waive the exhaustion requirement.

(6) If the requirement to exhaust the health insurance issuer's internal grievance procedures is waived under subsection (5), the covered person or, if applicable, the covered person's authorized representative may file a request in writing for a review under 33-32-410 or 33-32-412, as applicable.

History: En. Sec. 21, Ch. 428, L. 2015.

33-32-406 through 33-32-409 reserved.

33-32-410. Standard external review. (1) Within 120 days after the date of receipt of a notice of an adverse determination or a final adverse determination pursuant to 33-32-403, a covered person or, if applicable, the covered person's authorized representative may file a request for an external review with the health insurance issuer.

(2) Within 5 business days after the date of receipt of the external review request, the health insurance issuer shall complete a preliminary review of the request to determine whether:

(a) the individual is or was a covered person in the health plan at the time the health care service or treatment was requested or, in the case of a retrospective review, was a covered person in the health plan at the time the health care service or treatment was provided;

(b) the health care service or treatment that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health plan but is not covered because of a determination by the health insurance issuer that the health care service or treatment does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or level of effectiveness;

(c) the covered person has exhausted the health insurance issuer's internal grievance process as set forth in Title 33, chapter 32, part 3, or the covered person is exempt under 33-32-307(2); and

(d) the covered person or the covered person's authorized representative has provided all of the information and forms required to process an external review.

(3) (a) Within 1 business day after completion of the preliminary review, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative in writing as to whether:

(i) the request is complete; and

(ii) the request is eligible for external review.

(b) (i) If the request is not complete, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the information or materials that are needed to make the request complete.

(ii) If the request is not eligible for external review, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for the request's ineligibility.

(4) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (3) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under subsection (3) must include a statement informing the covered person or, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review.

(5) (a) If the commissioner receives an appeal under subsection (4), the commissioner may require a referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(b) A determination by the commissioner under subsection (5)(a) must be based on the terms of the covered person's health plan and all applicable provisions of Title 33, chapter 32, parts 2 through 4.

(6) (a) If the request is eligible for external review, the health insurance issuer shall within 1 business day assign an independent review organization on a random basis, or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 33-32-416 to conduct the external review.

(b) In making the assignment, the health insurance issuer shall consider whether an independent review organization is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(c) The health insurance issuer shall also take into account other circumstances, including conflict of interest concerns pursuant to 33-32-417(4).

(7) The assigned independent review organization, in reaching its decision, is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process set forth in Title 33, chapter 32, part 2, or the health insurance issuer's internal grievance process set forth in Title 33, chapter 32, part 3.

(8) Within 1 business day of assigning an independent review organization pursuant to subsection (6), the health insurance issuer shall notify, in writing, the covered person or, if applicable, the covered person's authorized representative that the health insurance issuer initiated an external review.

(9) The health insurance issuer shall include in the notice provided to the covered person or, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within 10 business days following the date of receipt of the notice provided pursuant to subsection (8) any additional information for the independent review organization to consider when conducting the external review. The independent review organization shall accept and consider information submitted within 10 business days after the date of receipt of the notice and may accept and consider additional information submitted after the 10 business days.

(10) Within 5 business days after assigning an independent review organization pursuant to subsection (6), the health insurance issuer or its designated utilization review organization shall provide to the assigned independent review organization the medical records, documents, and any information used in making the adverse determination or final adverse determination.

(11) Except as provided in subsection (12), failure by the health insurance issuer or its designated utilization review organization to provide the documents and information within the time specified in subsection (10) may not delay the conduct of the external review.

(12) (a) If the health insurance issuer or its designated utilization review organization fails to provide the documents and information within the time specified in subsection (10),

the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(b) Within 1 business day after making a decision under subsection (12)(a), the independent review organization shall notify the covered person or, if applicable, the covered person's authorized representative as well as the health insurance issuer.

(13) If the provisions of subsection (12) do not apply, the assigned independent review organization shall review all of the information and documents received pursuant to subsection (10) and any other information submitted in writing to the independent review organization by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (9).

(14) On receipt of any information submitted by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (9), the assigned independent review organization shall within 1 business day after receipt forward the information to the health insurance issuer.

(15) On receipt of the information, if any, forwarded as provided in subsection (14), the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(16) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to subsection (15) may not delay or terminate the external review.

(17) The external review may be terminated only if the health insurance issuer decides, on completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(18) (a) Within 1 business day after making a decision to reverse its adverse determination or final adverse determination, as provided in subsection (17), the health insurance issuer shall notify the following in writing of its decision:

(i) the covered person or, if applicable, the covered person's authorized representative; and

(ii) the assigned independent review organization.

(b) The assigned independent review organization shall terminate the external review on receipt of the notice from the health insurance issuer sent pursuant to subsection (18)(a).

(19) In addition to the documents and information provided pursuant to subsection (10), the assigned independent review organization shall consider the following information and documents in making a decision, to the extent the information or documents are available:

(a) the covered person's medical records;

(b) the attending health care professional's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, the covered person, the covered person's authorized representative, or the covered person's treating health care provider;

(d) the terms of coverage under the covered person's health plan with the health insurance issuer to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health plan with the health insurance issuer;

(e) the most appropriate practice guidelines, which must include generally accepted practice guidelines, evidence-based standards, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations;

(f) any applicable clinical review criteria developed and used by the health insurance issuer or its designated utilization review organization; and

(g) the opinion of the independent review organization's clinical peer after considering the provisions of subsections (19)(a) through (19)(f) to the extent the information or documents are available.

(20) Within 45 days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) the covered person or, if applicable, the covered person's authorized representative; and

(b) the health insurance issuer.

(21) The independent review organization shall include in the notice sent pursuant to subsection (20):

(a) a general description of the reason for the request for the external review;

(b) the date the independent review organization received the assignment from the health insurance issuer to conduct the external review;

(c) the time period over which the external review was conducted;

(d) the date of the independent review organization's decision;

(e) the principal reasons for the decision;

(f) the rationale for the decision; and

(g) references to the evidence or documentation, including the evidence-based standards, considered in reaching the decision.

(22) If a notice of a decision under subsection (20) reverses the adverse determination or final adverse determination, the health insurance issuer shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

History: En. Sec. 22, Ch. 428, L. 2015; amd. Sec. 41, Ch. 151, L. 2017.

33-32-411. Expedited external review. (1) Except as provided in subsection (11), a covered person or, if applicable, the covered person's authorized representative may request an expedited external review with the health insurance issuer at the time the covered person receives:

(a) an adverse determination if:

(i) the adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination under 33-32-309 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(ii) the covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as provided in 33-32-309; or

(b) a final adverse determination if:

(i) the covered person has a medical condition for which the timeframe for completion of a standard external review pursuant to 33-32-410 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(ii) the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility.

(2) (a) On receipt of the request pursuant to subsection (1), the health insurance issuer shall immediately determine whether the request meets the review requirements under 33-32-410(2).

(b) The health insurance issuer shall immediately notify the covered person or, if applicable, the covered person's authorized representative of its eligibility determination.

(3) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (2)(b) and any supporting information to be included in the notice.

(b) The notice of initial determination under subsection (2)(b) must include a statement informing the covered person or, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review. The notice must also provide contact information for the commissioner's office.

(4) (a) The commissioner may determine that a request is eligible for external review under 33-32-410(5) and require a referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(b) A determination by the commissioner under subsection (4)(a) must be based on the terms of the covered person's health plan and all applicable provisions of Title 33, chapter 32, parts 2 through 4.

(5) (a) If the request is eligible for external review, the health insurance issuer shall immediately assign an independent review organization on a random basis, or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 33-32-416 to conduct the review.

(b) In making the assignment, the health insurance issuer shall consider whether an independent review organization is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(c) The health insurance issuer shall also take into account other circumstances, including conflict of interest concerns pursuant to 33-32-417(4).

(6) In reaching a decision as provided in subsection (9), the assigned independent review organization is not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process, as provided in Title 33, chapter 32, part 2, or the health insurance issuer's internal grievance process provided in Title 33, chapter 32, part 3.

(7) Upon assigning an independent review organization, the health insurance issuer or its designated utilization review organization shall provide or transmit all necessary documents and information used in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(8) In addition to the documents and information provided under subsection (7), the assigned independent review organization, to the extent the information or documents are available, shall consider the documents listed in 33-32-410(19) in reaching a decision.

(9) (a) As expeditiously as the covered person's medical condition or circumstances require but no more than 72 hours after receiving the request for an expedited external review that meets the review requirements set forth in 33-32-410(2), the assigned independent review organization shall:

(i) decide whether to uphold or reverse the adverse determination or final adverse determination; and

(ii) notify the covered person or, if applicable, the covered person's authorized representative as well as the health insurance issuer of the decision.

(b) If the notice required under subsection (9)(a) was not provided in writing, the assigned independent review organization shall within 48 hours after the date of providing the notice:

(i) provide written confirmation of the decision to the covered person or, if applicable, the covered person's authorized representative as well as to the health insurance issuer; and

(ii) include the information required in 33-32-410(21).

(10) On receipt of the notice regarding a decision reversing the adverse determination or final adverse determination, the health insurance issuer shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination.

(11) An expedited external review may not be provided for retrospective adverse or retrospective final adverse determinations.

History: En. Sec. 23, Ch. 428, L. 2015.

33-32-412. External review of adverse determinations for experimental or investigational treatment — expedited external review. (1) Within 120 days after the date when a covered person or, if applicable, the covered person's authorized representative receives notice pursuant to 33-32-403 of an adverse determination or final adverse determination that involves a denial of coverage because a health insurance issuer determined that the health care service or treatment recommended or requested is experimental or investigational, the covered person or the covered person's authorized representative may file a request for an external review with the health insurance issuer.

(2) (a) A covered person or, if applicable, the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to subsection (1) if the covered person's treating health care provider certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(b) (i) Upon receipt of a request for an expedited external review, the health insurance issuer shall immediately determine and notify the covered person or, if applicable, the covered person's authorized representative whether the request meets the review requirements of subsection (4).

(ii) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (2)(b)(i) and any supporting information to be included in the notice.

(iii) The notice of initial determination under subsection (2)(b)(i) must include a statement informing the covered person or, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review. The notice must also provide contact information for the commissioner's office.

(c) (i) The commissioner may determine that a request is eligible for external review under 33-32-404 or subsection (4) of this section and may require a referral for external review, notwithstanding a health insurance issuer's initial determination that the request is ineligible.

(ii) A determination by the commissioner under subsection (2)(c)(i) must be based on the terms of the covered person's health plan and all applicable provisions of Title 33, chapter 32, parts 2 through 4.

(d) (i) If the request is eligible for expedited external review, the health insurance issuer shall immediately assign an independent review organization on a random basis, or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 33-32-416 to conduct the external review.

(ii) In making the assignment, the health insurance issuer shall consider whether an independent review organization is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(iii) The health insurance issuer shall also take into account other circumstances, including conflict of interest concerns pursuant to 33-32-417(4).

(e) Upon assigning an independent review organization, the health insurance issuer or its designated utilization review organization shall provide or transmit to the assigned independent review organization electronically, by telephone, by facsimile, or by any other available expeditious method all necessary documents and information used in making the adverse determination or final adverse determination.

(3) Upon receipt of a request for standard external review, the health insurance issuer shall, within 5 business days, determine whether the request meets the eligibility requirements of subsection (4).

(4) In accordance with the timeframes in subsections (2)(b) and (3), the health insurance issuer shall conduct and complete a preliminary review of the request to determine whether:

(a) the individual is or was a covered person in the health plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health plan at the time the health care service or treatment was provided;

(b) the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:

(i) is a covered benefit under the covered person's health plan except for the health insurance issuer's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(ii) is not explicitly listed as an excluded benefit under the covered person's health plan;

(c) the covered person's treating health care provider has certified that one of the following situations is applicable:

(i) standard health care services or treatments have not been effective in improving the condition of the covered person;

(ii) standard health care services or treatments are not medically appropriate for the covered person; or

(iii) there is no available standard health care service or treatment covered by the health insurance issuer that is more beneficial than the recommended or requested health care service or treatment described in subsection (4)(d);

(d) (i) the covered person's treating health care provider has recommended a health care service or treatment that the health care provider certifies, in writing, is likely to be more beneficial to the covered person, in the health care provider's opinion, than any available standard health care services or treatments; or

(ii) a physician who is licensed, board-certified, or eligible to take the examination to become board-certified and is qualified to practice in the area of medicine appropriate to treat the covered person's condition has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person who is subject to the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments; and

(e) the covered person has exhausted the health insurance issuer's internal grievance process provided in Title 33, chapter 32, part 3, or the covered person is exempt under 33-32-307(2).

(5) (a) Within 1 business day after completion of the preliminary review, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative in writing as to whether:

(i) the request is complete; and

(ii) the request is eligible for external review.

(b) (i) If the request is not complete, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the information or materials that are needed to make the request complete.

(ii) If the request is not eligible for external review, the health insurance issuer shall inform the covered person or, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for the request's ineligibility.

(6) (a) The commissioner may specify the form for the health insurance issuer's notice of initial determination under subsection (5) and any supporting information to be included in the notice.

(b) The notice of initial determination provided under subsection (5) must include a statement informing the covered person or, if applicable, the covered person's authorized representative of the right to appeal to the commissioner a health insurance issuer's initial determination that the external review request is ineligible for review. The notice must also provide contact information for the commissioner's office.

(7) If a request for external review is determined eligible for external review, the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative.

(8) (a) If the request is eligible for external review, the health insurance issuer shall within 1 business day assign an independent review organization on a random basis, or using another method of assignment that ensures the independence and impartiality of the assignment process, from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to 33-32-416 to conduct the external review.

(b) In making the assignment, the health insurance issuer shall consider whether an independent review organization is qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination or final adverse determination.

(c) The health insurance issuer shall also take into account other circumstances, including conflict of interest concerns pursuant to 33-32-417(4).

(9) Within 1 business day of assigning an independent review organization pursuant to subsection (2)(d) or (8), the health insurance issuer shall notify in writing the covered person or, if applicable, the covered person's authorized representative that the health insurance issuer initiated an external review.

(10) The health insurance issuer shall include in the notice provided to the covered person or, if applicable, the covered person's authorized representative a statement that the covered

person or, if applicable, the covered person's authorized representative may submit in writing to the assigned independent review organization within 10 business days following the date of receipt of the notice provided pursuant to subsection (9) any additional information for the independent review organization to consider when conducting the external review. The independent review organization shall accept and consider information submitted within 10 business days after the date of receipt of the notice and may accept and consider additional information submitted after the 10 business days.

(11) Within 1 business day after the receipt of the notice of assignment to conduct the external review pursuant to subsection (9), the assigned independent review organization shall select a clinical peer, or multiple peers if medically appropriate under the circumstances, to conduct the external review.

(12) (a) In selecting clinical peers to conduct the external review, the assigned independent review organization shall select physicians or other health care providers who meet the minimum qualifications described in 33-32-417 and who, through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

(b) The choice of the physicians or other health care providers to conduct the external review may not be made by the covered person, the covered person's authorized representative, if applicable, or the health insurance issuer.

(13) (a) In accordance with subsection (20), each clinical peer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.

(b) In reaching an opinion, clinical peers are not bound by any decisions or conclusions reached during the health insurance issuer's utilization review process provided for in Title 33, chapter 32, part 2, or in the health insurance issuer's internal grievance process provided for in Title 33, chapter 32, part 3.

(14) (a) Within 5 business days after assigning an independent review organization pursuant to subsection (9), the health insurance issuer or its designated utilization review organization shall provide to the assigned independent review organization any documents and information considered in making the adverse determination or the final adverse determination.

(b) Except as provided in subsection (15), failure by the health insurance issuer or its designated utilization review organization to provide the documents and information within the time specified in subsection (14)(a) may not delay the conduct of the external review.

(15) (a) If the health insurance issuer or its designated utilization review organization fails to provide the documents and information within the time specified in subsection (14)(a), the assigned independent review organization may terminate the external review and decide to reverse the adverse determination or final adverse determination.

(b) Immediately upon making the determination under subsection (15)(a), the independent review organization shall notify the covered person or, if applicable, the covered person's authorized representative, the health insurance issuer, and the commissioner.

(16) On receipt of any information submitted by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (10), the assigned independent review organization shall, within 1 business day after the receipt of the information, forward the information to the health insurance issuer.

(17) (a) On receipt of the information required to be forwarded pursuant to subsection (16), the health insurance issuer may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(b) Reconsideration by the health insurance issuer of its adverse determination or final adverse determination pursuant to subsection (17)(a) may not delay or terminate the external review.

(18) (a) The external review may be terminated only if the health insurance issuer decides, on completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.

(b) Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in subsection (18)(a), the health insurance issuer shall notify the covered person or, if applicable, the covered person's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(c) The assigned independent review organization shall terminate the external review on receipt of the notice from the health insurance issuer pursuant to subsection (18)(b).

(19) Each clinical peer selected pursuant to subsection (12) shall review all of the information and documents received pursuant to subsection (14) and any other information submitted in writing by the covered person or, if applicable, the covered person's authorized representative pursuant to subsection (10).

(20) (a) Except as provided in subsection (20)(c), within 20 days after being selected in accordance with subsection (12) to conduct the external review, each clinical peer shall provide an opinion to the assigned independent review organization pursuant to subsection (21) on whether the recommended or requested health care service or treatment should be covered.

(b) Except for an opinion provided pursuant to subsection (20)(c), each clinical peer's opinion must be in writing and must include the following information:

(i) a description of the covered person's medical condition;

(ii) a description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care services or treatments and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(iii) a description and analysis of any medical or scientific evidence considered in reaching the opinion;

(iv) a description and analysis of any evidence-based standard; and

(v) information on whether the clinical peer's rationale for the opinion is based on subsection (21)(a) or (21)(b).

(c) (i) For an expedited external review, each clinical peer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances require but no later than 5 calendar days after the clinical peer was selected in accordance with subsection (12).

(ii) If the opinion provided pursuant to subsection (20)(c)(i) was not in writing, the clinical peer shall provide to the assigned independent review organization written confirmation of the opinion within 48 hours after the date the opinion was delivered and include the information required under subsection (20)(b).

(21) In addition to the documents and information provided under this section, each clinical peer selected pursuant to subsection (12) shall consider the following information in reaching an opinion as required in subsection (20) to the extent that the information is available and the clinical peer considers the information to be appropriate:

(a) the covered person's pertinent medical records;

(b) the attending health care provider's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by the health insurance issuer, the covered person, the covered person's authorized representative, or the covered person's treating health care provider;

(d) the terms of coverage under the covered person's health plan with the health insurance issuer. The terms of coverage must be analyzed to ensure that, except for the health insurance issuer's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the clinical peer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health insurance issuer; and

(e) whether:

(i) the recommended or requested health care service or treatment has been approved by the food and drug administration, if applicable, for the condition;

(ii) the recommended or requested health care service or treatment is typically covered by other insurers or payers, such as medicare; or

(iii) medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be more beneficial to the covered person than any available standard health care service or treatment and that the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

(22) (a) Except as provided in subsection (22)(b), within 20 days after the date of receiving the opinion of each clinical peer pursuant to subsection (20), the assigned independent review organization shall make a decision and provide written notice of the decision to the covered person or, if applicable, the covered person's authorized representative as well as the health insurance issuer.

(b) (i) For an expedited external review, within 48 hours after the date of receiving the opinion of each clinical peer pursuant to subsection (20), the assigned independent review organization, in accordance with subsection (22)(c), shall make a decision and provide notice of the decision orally or in writing to the recipients listed in subsection (22)(a).

(ii) If the notice provided under subsection (22)(b)(i) was not in writing, within 48 hours after the date of providing that notice the assigned independent review organization shall provide written confirmation of the decision to the recipients listed in subsection (22)(a) and include the information set forth in subsection (22)(d).

(c) (i) If a majority of the clinical peers respond that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health insurance issuer's adverse determination or final adverse determination.

(ii) If a majority of the clinical peers respond that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health insurance issuer's adverse determination or final adverse determination.

(iii) If the clinical peers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical peer to help the independent review organization make a decision based on the opinions of a majority of the clinical peers pursuant to subsections (22)(c)(i) or (22)(c)(ii).

(iv) The additional clinical peer selected under subsection (22)(c)(iii) shall use the same information to reach an opinion as used by the clinical peers who have already submitted their opinions pursuant to subsection (20).

(v) The selection of the additional clinical peer under subsection (22)(c)(iii) may not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical peers.

(d) The independent review organization shall include in the notice provided pursuant to subsection (22)(b):

(i) a general description of the reason for the request for external review;

(ii) the written opinion of each clinical peer, including the opinion of each clinical peer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(iii) the date on which the independent review organization was assigned by the commissioner to conduct the external review;

(iv) the time period during which the external review was conducted;

(v) the date of the independent review organization's decision; and

(vi) the principal rationale for its decision.

(e) On receipt of a notice of a decision pursuant to subsection (22)(c)(i) reversing the adverse determination or final adverse determination, the health insurance issuer shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.

History: **En. Sec. 24, Ch. 428, L. 2015; amd. Sec. 42, Ch. 151, L. 2017.**

33-32-413 and 33-32-414 reserved.

33-32-415. Binding nature of external review decisions. (1) An external review decision is binding on:

(a) the health insurance issuer; and

(b) the covered person except to the extent that the covered person has other remedies available under applicable federal or state law.

(2) A covered person or, if applicable, the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this part.

History: En. Sec. 25, Ch. 428, L. 2015.

33-32-416. Approval of independent review organizations — renewal. (1) The commissioner shall approve independent review organizations that are eligible to conduct external reviews under this part.

(2) To be eligible for approval by the commissioner to conduct external reviews under this part, an independent review organization:

(a) must be accredited by a nationally recognized private accrediting entity as provided in subsection (5) and meet the minimum qualifications provided in 33-32-417; and

(b) shall submit an application fee as provided in 33-32-419 and an application for approval in accordance with subsection (4) or, for those currently approved and seeking renewal, a renewal fee and renewal application.

(3) The commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.

(4) (a) Any independent review organization seeking to be approved to conduct external reviews under this part shall submit the application form and include with the form all documentation, fees, and information necessary for the commissioner to determine whether the independent review organization satisfies the minimum qualifications established under 33-32-417 and subsection (5) of this section.

(b) An independent review organization that is currently approved and seeking renewal shall submit a renewal application, fees, and other information necessary for the commissioner to determine whether the independent review organization continues to satisfy the minimum qualifications established under 33-32-417 and subsection (5) of this section.

(5) An independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity approved by the commissioner as having independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under 33-32-417.

(6) The commissioner's approval of an independent review organization is effective for 2 years unless the commissioner determines before the expiration date that the independent review organization:

(a) is not satisfying the minimum qualifications established under 33-32-417; or

(b) has not fulfilled the reporting requirements under 33-32-421.

(7) If the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under 33-32-417, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations maintained by the commissioner pursuant to subsection (9).

(8) If the commissioner determines that an independent review organization has not fulfilled the reporting requirements contained in 33-32-421, the commissioner may terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations maintained by the commissioner pursuant to subsection (9).

(9) The commissioner shall maintain and periodically update a list of approved independent review organizations.

(10) A person may not operate as an independent review organization in Montana unless approved by the commissioner.

History: En. Sec. 26, Ch. 428, L. 2015; amd. Sec. 2, Ch. 31, L. 2019.

33-32-417. Minimum qualifications for independent review organizations. (1) To be approved to conduct external reviews as provided in 33-32-416, an independent review organization shall establish and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in 33-32-410 through 33-32-412. The written policies and procedures must include, at a minimum:

(a) a quality assurance mechanism that ensures:

(i) that external reviews are conducted within the specified timeframes and that required notices are provided in a timely manner;

(ii) that the independent review organization is unbiased;

(iii) both the selection of qualified and impartial clinical peers to conduct external reviews on behalf of the independent review organization and the suitable matching of reviewers to specific cases;

(iv) that the independent review organization employs or contracts with an adequate number of clinical peers to meet the objective of qualified, impartial reviews;

(v) the confidentiality of medical and treatment records as well as clinical review criteria; and

(vi) that any person employed by or under contract with the independent review organization adheres to the requirements of this part;

(b) a toll-free telephone service to receive information related to external reviews on a 24-hour-a-day, 7-day-a-week basis. The telephone service must be capable of accepting, recording, or providing appropriate instruction to incoming telephone callers during other-than-normal business hours.

(c) an agreement to maintain and provide to the commissioner the information required under 33-32-421.

(2) All clinical peers assigned by an independent review organization to conduct external reviews must:

(a) be appropriate health care providers; and

(b) meet the following minimum qualifications:

(i) be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(ii) be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical conditions of the covered person;

(iii) hold a nonrestricted professional license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in one or more areas appropriate to the subject of the external review; and

(iv) have no history of disciplinary actions or sanctions, including participation restrictions or a loss of staff privileges either taken or pending by any hospital, government agency, governmental unit, or regulatory body if the disciplinary actions or sanctions raise a substantial question as to the clinical peer's physical, mental, or professional competence or moral character.

(3) In addition to the requirements in subsection (1), an independent review organization may not own or control, be a subsidiary of, or in any way be owned or controlled by or exercise control over a health plan, a health insurance issuer, a national, state, or local trade association of health plans, or a national, state, or local trade association of health care providers.

(4) (a) In addition to the requirements in subsections (1) through (3), to be approved under 33-32-416 to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical peer assigned by the independent review organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(i) the health insurance issuer that is the subject of the external review;

(ii) the covered person whose treatment is the subject of the external review or, if applicable, the covered person's authorized representative;

(iii) any officer, director, or management employee of the health insurance issuer that is the subject of the external review;

(iv) the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the external review;

(v) the facility at which the recommended health care service or treatment would be provided; or

(vi) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(b) In determining whether an independent review organization or a clinical peer assigned by the independent review organization to conduct the external review has a material professional, familial, or financial conflict of interest, the commissioner shall take into consideration:

(i) situations in which the independent review organization to be assigned to conduct an external review of a specified case or a clinical peer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial, or financial relationship or connection with a person described in subsection (4)(a) if the characteristics of that relationship or connection do not pose a material professional, familial, or financial conflict of interest that otherwise would result in the disapproval of the independent review organization or of the clinical peer from conducting the external review; and

(ii) whether other medical expertise is available within a reasonable timeframe.

(5) (a) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards determined by the commissioner to be equivalent to or exceed the minimum qualifications of this section is presumed to be in compliance with this section and eligible for approval under 33-32-416. However, the commissioner shall also consider the conflict of interest provisions of subsection (4).

(b) The commissioner shall initially and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are and continue to be equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the determination under this subsection (5)(b).

(c) On request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC to enable the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

History: En. Sec. 27, Ch. 428, L. 2015; amd. Sec. 43, Ch. 151, L. 2017.

33-32-418. Liability limits for independent review organization. (1) Except as provided in subsection (2), an independent review organization or clinical peer working on behalf of an independent review organization or an employee, agent, or contractor of an independent review organization is not liable to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this part.

(2) The liability exemption under subsection (1) does not apply if the opinion was rendered or if the act or omission was performed in bad faith or involved gross negligence.

History: En. Sec. 28, Ch. 428, L. 2015.

33-32-419. Fees. (1) An application for approval of an independent review organization under 33-32-416 must be accompanied by a fee of $250.

(2) An application for renewal as an approved independent review organization must be accompanied by a fee of $150.

History: En. Sec. 1, Ch. 31, L. 2019.

33-32-420 reserved.

33-32-421. External review reporting requirements. (1) An independent review organization assigned pursuant to 33-32-410, 33-32-411, or 33-32-412 to conduct an external review shall maintain written records in the aggregate by state and by health insurance issuer on all requests for external reviews for which the independent review organization conducted an external review during the calendar year.

(2) Each independent review organization required to maintain written records as provided in subsection (1) shall submit to the commissioner, at least annually by March 1, a report in the format specified by the commissioner.

(3) The report must include, aggregated by state and by health insurance issuer:

(a) the total number of requests for external review;

(b) the number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(c) the average length of time for resolution;

(d) a summary of the types of coverages or cases for which an external review was sought, provided in the format required by the commissioner;

(e) the number of external reviews that were terminated pursuant to 33-32-410(17) or 33-32-412(15) as the result of a reconsideration by the health insurance issuer of its adverse determination or final adverse determination after the receipt of additional information from the covered person or, if applicable, the covered person's authorized representative; and

(f) any other information the commissioner may request or require.

(4) The independent review organization shall retain the written records required pursuant to subsection (1) for at least 6 years.

(5) Each health insurance issuer shall maintain in the aggregate for each type of health plan offered by the health insurance issuer written records on all requests for external review for which the health insurance issuer received notice pursuant to Title 33, chapter 32, parts 2 through 4.

(6) Each health insurance issuer required to maintain written records on all requests for external review pursuant to subsection (5) shall submit to the commissioner, at least annually by March 1, a report in the format specified by the commissioner.

(7) The report must include in the aggregate by state and by type of health plan:

(a) the total number of requests for external review;

(b) the number of requests determined eligible for a full external review based on the total number of requests for external review reported under subsection (7)(a);

(c) the number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(d) the average length of time for resolution;

(e) a summary of the types of coverage or cases for which an external review was sought, as provided in the format required by the department;

(f) the number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or, if applicable, the covered person's authorized representative; and

(g) any other information the commissioner may request or require.

(8) The health insurance issuer shall retain the written records required pursuant to subsection (5) for at least 6 years.

History: **En. Sec. 29, Ch. 428, L. 2015; amd. Sec. 3, Ch. 31, L. 2019.**

33-32-422. Funding of external review. The health insurance issuer against which a request for a standard external review or an expedited external review is filed shall pay the costs of the independent review organization for conducting the external review.

History: **En. Sec. 30, Ch. 428, L. 2015.**

33-32-423. Disclosure requirements. (1) Each health insurance issuer shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(2) The disclosure required under subsection (1) must:

(a) be in a format prescribed by the commissioner; and

(b) include a statement that informs the covered person of the right of the covered person or, if applicable, the covered person's authorized representative to file a request for an external review of an adverse determination or final adverse determination with the health insurance issuer. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care, or level of effectiveness. The statement must include the telephone number and address of the commissioner.

(3) In addition to the requirements under subsection (2), the statement must inform the covered person that, when filing a request for an external review, the covered person or, if applicable, the covered person's authorized representative is required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

History: En. Sec. 31, Ch. 428, L. 2015; amd. Sec. 44, Ch. 151, L. 2017.

CHAPTER 33
PROPERTY AND CASUALTY UTILIZATION REVIEW

Part 1 — General Provisions

33-33-101. Purpose.
33-33-102. Scope — rulemaking.
33-33-103. Definitions.

Part 2 — Standards

33-33-201. Standards for utilization review organizations.
33-33-202. Standards for property and casualty insurers.

Part 1
General Provisions

33-33-101. Purpose. The legislature recognizes that property and casualty insurers providing coverage for medical expenses or liability coverage for bodily injury may need, with respect to some claims, to seek medical reviews from qualified utilization review organizations so that an insurer may use the reviews to determine its contractual obligations. This chapter establishes standards for organizations providing utilization reviews and for property and casualty insurers seeking reviews.

History: En. Sec. 1, Ch. 335, L. 2001.

33-33-102. Scope — rulemaking. (1) This chapter applies to property and casualty insurers seeking utilization review opinions and to utilization review organizations that provide opinions with respect to property and casualty insurance contracts issued in this state.

(2) The commissioner may adopt rules to implement the provisions of this chapter, including but not limited to medical privacy requirements.

History: En. Sec. 2, Ch. 335, L. 2001; amd. Sec. 34, Ch. 157, L. 2023.

33-33-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Utilization review" has the meaning provided in 33-32-102.

(2) "Utilization review organization" means an entity that provides utilization review services.

History: En. Sec. 3, Ch. 335, L. 2001; amd. Sec. 39, Ch. 428, L. 2015.

Part 2
Standards

33-33-201. Standards for utilization review organizations. (1) A utilization review organization that conducts utilization reviews in this state for property and casualty insurers shall meet the standards set forth in this part.

(2) Utilization review organizations may use only licensed or certified health care professionals to conduct utilization reviews.

(3) Utilization reviews must be conducted by health care professionals who are licensed or certified in the same specialty as the provider whose treatment is being received by the insured or by a health care professional who is qualified to render the treatment being reviewed.

(4) Utilization review organizations shall comply with all applicable state or federal medical privacy laws.

(5) Utilization review evaluations must use generally accepted standards for treatment of the illness, injury, or condition that is being reviewed.

(6) Utilization review opinions must be signed by the health care professional performing the review.

(7) A utilization review organization may not base its fees or charges on any recommendation for a reduction in payment under an insurance contract or on a percentage of claim savings.

History: En. Sec. 4, Ch. 335, L. 2001; amd. Sec. 35, Ch. 157, L. 2023.

33-33-202. Standards for property and casualty insurers. (1) Property or casualty insurers seeking utilization reviews with respect to insurance contracts issued in this state may use only utilization review organizations that meet the requirements of this part and any rules adopted pursuant to this part.

(2) A property or casualty insurer is responsible for:

(a) monitoring all utilization review activities carried out by or on behalf of the property or casualty insurer;

(b) ensuring that all requirements of this part and rules adopted pursuant to this part are met; and

(c) ensuring that appropriate personnel have operational responsibility for and oversight of the performance of the property or casualty insurer's utilization review program and contracts with utilization review organizations.

(3) A property or casualty insurer that denies, in whole or in part, a policyholder's claim after consideration of a utilization review shall provide the policyholder an opportunity to request reconsideration by the insurer and the opportunity to submit additional information relating to the claim.

History: En. Sec. 5, Ch. 335, L. 2001; amd. Sec. 36, Ch. 157, L. 2023.

CHAPTER 34
RESERVED

CHAPTER 35
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Part 1 — General Provisions

33-35-101. Short title.
33-35-102. Purpose.
33-35-103. Definitions.

Part 2 — Certificate of Authority

33-35-201. Certificate of authority.
33-35-202. Eligibility for certificate of authority.
33-35-203. Requirements applicable only to arrangements organized after October 1, 1995.
33-35-204 reserved.
33-35-205. Application for certificate of authority.
33-35-206 through 33-35-208 reserved.
33-35-209. Minimum reserve requirements.
33-35-210. Minimum funding levels.
33-35-211. Issuance of certificate of authority.

Part 3 — Enforcement

33-35-301. Reporting.
33-35-302. Failure to comply.
33-35-303. Violation by arrangement failing to obtain or maintain certificate of authority.
33-35-304 and 33-35-305 reserved.

33-35-306. Application of insurance code to arrangements.
33-35-307. Disclosure.

Chapter Cross-References

Guaranteed renewability in multiple employer welfare arrangements, 33-22-525.

Part 1
General Provisions

33-35-101. Short title. This chapter may be cited as the "Self-Funded Multiple Employer Welfare Arrangement Regulation Act".

History: En. Sec. 1, Ch. 420, L. 1995.

33-35-102. Purpose. The purposes of this chapter are to:

(1) provide for the authorization and registration of self-funded multiple employer welfare arrangements;

(2) regulate self-funded multiple employer welfare arrangements in order to ensure the financial integrity of the arrangements;

(3) provide reporting requirements for self-funded multiple employer welfare arrangements; and

(4) provide for sanctions against self-funded multiple employer welfare arrangements organized and maintained in Montana that do not comply with this chapter.

History: En. Sec. 2, Ch. 420, L. 1995.

33-35-103. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Allowable benefit" means a benefit relating to medical, surgical, or hospital care in the event of sickness, accident, disability, or any combination of sickness, accident, or disability.

(2) (a) "Bona fide association" means an association of employers that has been in existence for a period of not less than 5 years prior to sponsoring a self-funded multiple employer welfare arrangement, during which time the association has engaged in substantial activities relating to the common interests of member employers, and that continues to engage in substantial activities in addition to sponsoring an arrangement.

(b) Notwithstanding subsection (2)(a), an association that was formed and began sponsoring an arrangement prior to October 1, 1995, is not subject to the requirement that the association be in existence for 5 years prior to sponsoring an arrangement.

(3) "Claims liability" means the total of all incurred and unpaid claims for allowable benefits under a self-funded multiple employer welfare arrangement that are not reimbursed or reimbursable by excess of loss insurance, subrogation, or other sources.

(4) (a) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined by 29 U.S.C. 1002.

(b) The term does not include an arrangement, plan, program, or interlocal agreement of or between political subdivisions of this state, including school districts, as provided in 33-1-102.

(5) "Reserves" means the excess of the assets of a self-funded multiple employer welfare arrangement minus the liabilities of the arrangement. The liabilities of a self-funded multiple employer welfare arrangement include the claims liability of the arrangement.

(6) "Self-funded multiple employer welfare arrangement" or "arrangement" means a multiple employer welfare arrangement that does not provide for payment of benefits under the arrangement solely through a policy or policies of insurance issued by one or more insurance companies with a certificate of authority under this title.

History: En. Sec. 3, Ch. 420, L. 1995; amd. Sec. 25, Ch. 399, L. 2007.

Part 2
Certificate of Authority

33-35-201. Certificate of authority. (1) Except as provided in subsection (3), a person may not establish or maintain a self-funded multiple employer welfare arrangement in Montana unless the arrangement first obtains a certificate of authority from the commissioner.

(2) A self-funded multiple employer welfare arrangement is considered to be established or maintained in Montana if one or more of the employer members participating in the arrangement is either domiciled in or maintains its principal place of business in Montana.

(3) A self-funded multiple employer welfare arrangement established and maintained in Montana prior to January 1, 1995, has until April 1, 1996, to file an application for a certificate of authority. An arrangement that files an application for a certificate of authority by that date is considered to have been issued a certificate of authority unless the commissioner finally denies the arrangement's application for a certificate of authority.

History: **En. Sec. 4, Ch. 420, L. 1995.**

33-35-202. Eligibility for certificate of authority. The commissioner may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless the arrangement establishes to the reasonable satisfaction of the commissioner that the following requirements have been satisfied by the arrangement:

(1) the employers participating in the self-funded multiple employer welfare arrangement are either engaged in the same trade, profession, or industry or the employers participating in the arrangement are members of a bona fide association;

(2) the employers participating in the arrangement exercise control over the arrangement, as follows:

(a) Subject to subsection (2)(b), control exists if the employers participating in the arrangement have the right to elect at least 75% of the individuals designated in the arrangement's organizational documents as having control over the operations of the arrangement and the individuals designated in the arrangement's organizational documents in fact exercise control over the operation of the arrangement.

(b) The use of a third-party administrator to process claims and to assist in the administration of the arrangement is not evidence of the lack of exercise of control over the operation of the arrangement.

(3) the arrangement provides only allowable benefits. However, an arrangement may provide life insurance coverage to its participants if the coverage is provided pursuant to contracts of insurance that comply with Title 33, chapter 20, parts 10 through 12.

(4) the arrangement provides allowable benefits to not less than 2 employers and not less than 75 employees;

(5) the arrangement may not solicit participation in the arrangement from the general public. However, the arrangement may employ or independently contract with a licensed insurance producer who may be paid a commission or other remuneration to enroll employers in the arrangement, and employees of the arrangement, employees of the association sponsoring the arrangement, or employees of affiliates of the association, other than licensed insurance producers, may enroll employers in the arrangement if the employees do not receive a commission or other remuneration in addition to their customary compensation for enrolling employers.

(6) the arrangement is not organized or maintained solely as a conduit for the collection of premiums and the forwarding of premiums to an insurance company. However, it is permissible for a self-funded multiple employer welfare arrangement to act as a conduit for the collection and forwarding of premiums for life insurance coverage pursuant to subsection (3).

History: **En. Sec. 5, Ch. 420, L. 1995.**

33-35-203. Requirements applicable only to arrangements organized after October 1, 1995. (1) In addition to the requirements of 33-35-202, self-funded multiple employer welfare arrangements formed after October 1, 1995, are subject to the following requirements:

(a) arrangements shall maintain a calendar year for operations and reporting purposes unless the commissioner consents to a fiscal year;

(b) arrangements shall satisfy one of the following requirements:

(i) (A) the arrangement shall deposit $200,000 with the commissioner pursuant to Title 33, chapter 2, part 6, to be used for the payment of claims in the event that the arrangement becomes insolvent; and

(B) the arrangement shall submit to the commissioner a written plan of operation that, in the reasonable discretion of the commissioner, ensures the financial integrity of the arrangement; or

(ii) the arrangement demonstrates to the reasonable satisfaction of the commissioner the ability of the arrangement to remain financially solvent, for which purpose the commissioner may consider:

(A) the pro forma financial statements of the self-funded multiple employer welfare arrangement;

(B) the types and levels of excess of loss insurance coverage, including the attachment points of the coverage and whether the points are reflected as annual or monthly levels;

(C) whether a deposit is required for each employee covered under the arrangement equal to at least one month's cost of providing benefits under the arrangement;

(D) the experience of the individuals who will be involved in the management of the arrangement, including employees, independent contractors, and consultants; and

(E) other factors as reasonably determined by the commissioner to be relevant to a determination of whether the arrangement is able to operate in a financially solvent manner.

(2) Financial information relating to the employers is subject to the confidentiality provisions of 33-1-409(6).

(3) The commissioner may require that the articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of the employers, employees, and beneficiaries of the arrangement provide that employers participating in the arrangement are subject to pro rata assessment for all liabilities of the arrangement.

(4) Arrangements shall maintain excess of loss insurance coverage covering 100% of claims in excess of the designated attachment point. The commissioner may waive the requirement of excess of loss insurance coverage.

(5) An arrangement shall submit its base contribution rates for participation under the arrangement for its initial year of operations for review and approval by the commissioner.

(6) The commissioner may require continued compliance with respect to the conditions set forth in this section as a condition of granting a certificate of authority to an arrangement. The commissioner may waive continued compliance with respect to the conditions in this section at any time after the commissioner has granted a certificate of authority to an arrangement.

History: En. Sec. 6, Ch. 420, L. 1995.

33-35-204 reserved.

33-35-205. Application for certificate of authority. A self-funded multiple employer welfare arrangement shall apply for a certificate of authority on a form prescribed by the commissioner and shall submit the application, together with the following documents, to the commissioner:

(1) a copy of all articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of the employers, employees, and beneficiaries of the arrangement;

(2) a copy of the summary plan description or summary plan descriptions of the arrangement filed or required to be filed with the United States department of labor, together with any amendments to the description;

(3) evidence of coverage of or letters of intent to participate executed by at least 2 employers providing allowable benefits to at least 75 employees;

(4) a copy of the arrangement's most recent year's financial statements or, if the arrangement has been in existence for less than 1 year, pro forma financial statements that must include, at a minimum, a balance sheet, an income statement, a statement of changes in financial position, and an actuarial opinion that the unpaid claim liability of the arrangement satisfies the standards of 33-2-514. The commissioner may, in the commissioner's discretion, waive the requirement of an actuarial opinion and require a report by an actuarial firm.

(5) proof that the arrangement maintains or will maintain fidelity bonds required by the United States department of labor pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.;

(6) a copy of any excess of loss insurance coverage policies maintained or proposed to be maintained by the arrangement;

(7) biographical reports on forms prescribed by the national association of insurance commissioners evidencing the general trustworthiness and competence of each individual who is serving or who will serve as an employee or fiduciary of the arrangement; and

(8) a statement executed by a representative of the arrangement certifying, to the best knowledge and belief of the representative, that:

(a) the arrangement is in compliance with requirements of 33-35-202;

(b) the arrangement is in compliance with the requirements of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq., or a statement of any requirements with which the arrangement is not in compliance and a statement of proposed corrective actions; and

(c) the arrangement is in compliance with requirements of 33-35-209 and 33-35-210.

History: En. Sec. 7, Ch. 420, L. 1995.

33-35-206 through 33-35-208 reserved.

33-35-209. Minimum reserve requirements. Self-funded multiple employer welfare arrangements shall establish by the end of the first year of operations of the arrangement and shall maintain as of the end of each year of operations reserves equal to at least 30% of the unpaid claims liability of the arrangement. The commissioner may adopt rules regarding the supervision, rehabilitation, and liquidation of self-funded multiple employer welfare arrangements that fail to maintain the level of reserves required by this section.

History: En. Sec. 8, Ch. 420, L. 1995.

33-35-210. Minimum funding levels. A self-funded multiple employer welfare arrangement shall establish and maintain contribution rates for participation under the arrangement that satisfy either of the following requirements:

(1) contribution rates must equal or exceed the sum of projected claims liability for the year, plus all projected costs of operation of the arrangement for the year, plus an amount equal to any deficiency in the reserves of the arrangement for the prior year, minus an amount equal to the reserves of the arrangement in excess of the minimum required level of reserves; or

(2) contribution rates must equal or exceed a funding level established by a report prepared by an actuarial firm.

History: En. Sec. 9, Ch. 420, L. 1995.

33-35-211. Issuance of certificate of authority. (1) The commissioner shall grant or deny an application for a certificate of authority within 180 days of the date that a completed application, together with the items designated in 33-35-205, is submitted to the commissioner.

(2) The commissioner shall grant the application of an arrangement that satisfies the applicable requirements of 33-35-202, 33-35-203, 33-35-205, 33-35-209, and 33-35-210.

(3) The commissioner shall deny the application of an arrangement that does not satisfy the applicable requirements of 33-35-202, 33-35-203, 33-35-205, 33-35-209, and 33-35-210. Denial of an application for a certificate of authority is considered a contested case under the Montana Administrative Procedure Act.

(4) A certificate of authority granted to an arrangement is effective unless revoked by the commissioner under 33-35-302.

History: En. Sec. 10, Ch. 420, L. 1995.

Part 3
Enforcement

33-35-301. Reporting. (1) A self-funded multiple employer welfare arrangement shall comply with the reporting requirements of this section.

(2) Within 3 months following the close of the arrangement's year of operations, the arrangement shall file with the commissioner, on forms prescribed by the commissioner:

(a) a statement of financial condition;

(b) a statement of change in financial conditions accompanied by an actuarial opinion that the unpaid claim liability of the arrangement satisfies the standards of 33-2-514. The commissioner may, in the commissioner's discretion, waive the requirement of an actuarial opinion and require a report prepared by an actuarial firm and, upon a showing of good cause, may extend by 30 days the filing date for the report.

(c) a statement of its contribution rates for the ensuing year;

(d) a statement of operations for the previous year;

(e) if the total payments to the arrangement for participation during the prior year of operations exceeded the sum of $2 million, an audit satisfying the requirements of the commissioner's rules governing annual audited reports, except that an arrangement audit may be prepared using generally accepted accounting principles. The audit must be certified by an independent certified public accountant. The filing date for the audit must be extended by the commissioner upon a showing of good cause.

(f) additional information as the commissioner reasonably determines to be necessary to determine the financial integrity of the management.

(3) An arrangement shall file with the commissioner a copy of the arrangement's internal revenue service form 5500 together with all attachments to the form, at the time required for filing the form.

History: **En. Sec. 11, Ch. 420, L. 1995; amd. Sec. 32, Ch. 63, L. 2015.**

33-35-302. Failure to comply. (1) Pursuant to 33-1-317 and 33-1-318, the commissioner may impose sanctions against a self-funded multiple employer welfare arrangement that fails to comply with the provisions of this chapter. The maximum fine may not exceed $5,000 for each violation.

(2) The commissioner may issue a notice of intent to revoke the certificate of authority of a self-funded multiple employer welfare arrangement that fails to comply with the provisions of 33-35-209, 33-35-210, or 33-35-301. If, within 60 days of receiving notice under this subsection, the arrangement fails to file with the commissioner a plan to bring the arrangement into compliance with 33-35-209, 33-35-210, or 33-35-301, the commissioner may revoke the arrangement's certificate of authority. A revocation of a certificate of authority is a contested case under the Montana Administrative Procedure Act.

(3) The commissioner shall adopt rules to provide sanctions for an arrangement that fails to maintain the level of reserves required by 33-35-209. The rules must be consistent with the provisions of Title 33, chapter 2, part 13.

History: **En. Sec. 12, Ch. 420, L. 1995.**

33-35-303. Violation by arrangement failing to obtain or maintain certificate of authority. A self-funded multiple employer welfare arrangement organized or maintained in Montana without a certificate of authority is in violation of 33-2-101.

History: **En. Sec. 13, Ch. 420, L. 1995.**

33-35-304 and 33-35-305 reserved.

33-35-306. *(Temporary)* **Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) Title 33, chapter 2, parts 23 and 24;

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(i) 33-22-107, 33-22-114, 33-22-128, 33-22-129, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, and 33-22-152 through 33-22-155;

(j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526;

(k) Title 33, chapter 22, parts 7 and 21; and

(l) 33-22-707.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked.

33-35-306. *(Effective October 1, 2026)* **Application of insurance code to arrangements.** (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:

(a) 33-1-111;

(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(c) Title 33, chapter 1, part 7;

(d) Title 33, chapter 2, parts 23 and 24;

(e) 33-3-308;

(f) Title 33, chapter 7;

(g) Title 33, chapter 18, except 33-18-242;

(h) Title 33, chapter 19;

(i) 33-22-107, 33-22-114, 33-22-128, 33-22-129, 33-22-131, 33-22-134, 33-22-135, 33-22-138, 33-22-139, 33-22-141, 33-22-142, 33-22-149, and 33-22-152 through 33-22-155;

(j) 33-22-512, 33-22-515, 33-22-525, and 33-22-526;

(k) Title 33, chapter 22, parts 7 and 21; and

(l) 33-22-707.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked.

History: En. Sec. 14, Ch. 420, L. 1995; amd. Sec. 7, Ch. 410, L. 1997; amd. Sec. 32, Ch. 416, L. 1997; amd. Sec. 5, Ch. 434, L. 1999; amd. Sec. 49, Ch. 380, L. 2003; amd. Sec. 8, Ch. 384, L. 2003; amd. Sec. 2, Ch. 249, L. 2007; amd. Sec. 9, Ch. 356, L. 2007; amd. Sec. 6, Ch. 390, L. 2007; amd. Sec. 26, Ch. 399, L. 2007; amd. Sec. 5, Ch. 359, L. 2009; amd. Sec. 5, Ch. 97, L. 2013; amd. Sec. 4, Ch. 164, L. 2013; amd. Sec. 10, Ch. 363, L. 2013; amd. Sec. 4, Ch. 256, L. 2015; amd. Sec. 10, Ch. 231, L. 2017; amd. Sec. 8, Ch. 245, L. 2017; amd. Sec. 4, Ch. 209, L. 2021; amd. Sec. 4, Ch. 277, L. 2021; amd. Sec. 3, Ch. 323, L. 2021; amd. Sec. 19, Ch. 501, L. 2021; amd. Sec. 3, Ch. 88, L. 2023; amd. Sec. 4, Ch. 179, L. 2023; amd. Sec. 3, Ch. 463, L. 2023; amd. Sec. 4, Ch. 520, L. 2023; amd. Sec. 4, Ch. 600, L. 2023; amd. Sec. 7, Ch. 782, L. 2023; amd. Sec. 32, Ch. 8, L. 2025; amd. Sec. 7, Ch. 709, L. 2025.

Compiler's Comments

2025 Amendments — Composite Section: See 2025 Session Law for amendment made by sec. 32, Ch. 8, L. 2025. Amendment effective October 1, 2025.

See 2025 Session Law for amendment made by sec. 7, Ch. 709, L. 2025. Amendment effective October 1, 2026.

33-35-307. Disclosure. Each policy issued by a self-funded multiple employer welfare arrangement must contain, in 10-point type on the front page and the declaration page, the following notice:

“NOTICE

This policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a self-funded multiple employer welfare arrangement.”

History: En. Sec. 15, Ch. 420, L. 1995.

CHAPTER 36
MANAGED CARE PLAN NETWORK ADEQUACY AND QUALITY ASSURANCE

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Chapter Cross-References

Disability insurance, Title 33, ch. 22.
Workers' compensation — managed care and preferred provider organizations, Title 39, ch. 71, part 11.
Medicaid managed care — capitated health care, 53-6-116.
Medicaid managed care, Title 53, ch. 6, part 7.

Part 1
General Provisions

33-36-101. Short title. This chapter may be cited as the "Managed Care Plan Network Adequacy and Quality Assurance Act".

History: En. Sec. 8, Ch. 413, L. 1997.

33-36-102. Purpose. The purpose and intent of this chapter are to:

(1) establish standards for the creation and maintenance of networks by health carriers offering managed care plans and to ensure the adequacy, accessibility, and quality of health care services offered under a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons;

(2) provide for the implementation of state network adequacy and quality assurance standards in administrative rules, provide for monitoring compliance with those standards, and provide a mechanism for detecting and reporting violations of those standards to the commissioner;

(3) establish minimum criteria for the quality assessment activities of a health carrier issuing a closed plan or a combination plan and to require that minimum state quality assessment criteria be adopted by rule;

(4) enable health carriers to evaluate, maintain, and improve the quality of health care services provided to covered persons; and

(5) provide a streamlined and simplified process by which managed care network adequacy and quality assurance programs may be monitored for compliance through efforts by the commissioner. It is not the purpose or intent of this chapter to apply quality assurance standards applicable to medicaid or medicare to managed care plans regulated pursuant to this chapter or to create or require the creation of quality assurance programs that are as comprehensive as quality assurance programs applicable to medicaid or medicare.

History: En. Sec. 9, Ch. 413, L. 1997; amd. Sec. 38, Ch. 157, L. 2023.

33-36-103. Definitions. As used in this chapter, the following definitions apply:

(1) "Closed plan" means a managed care plan that requires covered persons to use only participating providers under the terms of the managed care plan.

(2) "Combination plan" means an open plan with a closed component.

(3) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(4) "Covered person" means a policyholder, subscriber, or enrollee or other individual participating in a health benefit plan.

(5) "Emergency medical condition" means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(a) the covered person's health would be in serious jeopardy;

(b) the covered person's bodily functions would be seriously impaired; or

(c) a bodily organ or part would be seriously damaged.

(6) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(7) "Facility" means an institution providing health care services or a health care setting, including but not limited to a hospital, critical access hospital, or rural emergency hospital, as those terms are defined in 50-5-101, or other licensed inpatient center, an outpatient center for surgical services, a treatment center, a skilled nursing center, a residential treatment center, a diagnostic laboratory, a diagnostic imaging center, or a rehabilitation or other therapeutic health setting.

(8) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

(9) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified pursuant to the laws of this state to perform specified health care services consistent with state law.

(10) "Health care provider" or "provider" means a health care professional or a facility.

(11) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(12) "Health carrier" means an entity subject to the insurance laws and rules of this state that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a disability insurer, health maintenance organization, or health service corporation or another entity providing a health benefit plan.

(13) "Intermediary" means a person authorized to negotiate, execute, and be a party to a contract between a health carrier and a provider or between a health carrier and a network.

(14) "Managed care plan" means a health benefit plan that either requires or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with, or employed by a health carrier, but not preferred provider organizations or other provider networks operated in a fee-for-service indemnity environment.

(15) "Medically necessary" means services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a covered person's illness, injury, or medical condition according to accepted standards of medical practice and that are not provided only as a convenience.

(16) "Network" means the group of participating providers that provides health care services to a managed care plan.

(17) "Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

(18) "Participating provider" means a provider who, under a contract with a health carrier or with the health carrier's contractor, subcontractor, or intermediary, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier.

(19) "Primary care professional" means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and to maintain supervision of health care services rendered to the covered person.

(20) "Quality assessment" means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations.

(21) "Quality assurance" means quality assessment and quality improvement.

(22) "Quality improvement" means an effort to improve the processes and outcomes related to the provision of health care services within a health plan.

History: En. Sec. 10, Ch. 413, L. 1997; amd. Sec. 2, Ch. 192, L. 2001; amd. Sec. 6, Ch. 502, L. 2007; amd. Sec. 39, Ch. 157, L. 2023; amd. Sec. 3, Ch. 602, L. 2023; amd. Sec. 2, Ch. 414, L. 2025.

Compiler's Comments

2025 Amendment: See 2025 Session Law for amendment made by sec. 2, Ch. 414, L. 2025. Amendment effective October 1, 2025.

33-36-104. Applicability and scope. This chapter applies to all health carriers that offer managed care plans. This chapter does not exempt a health carrier from the applicable requirements of federal law when providing a managed care plan to medicare recipients or from the applicable requirements of federal law or Title 53, chapter 6, when providing a managed care plan to medicaid recipients.

History: En. Sec. 11, Ch. 413, L. 1997.

33-36-105. Commissioner — general powers and duties — rulemaking. (1) The commissioner shall:

(a) adopt rules pursuant to the Montana Administrative Procedure Act establishing minimum state standards for network adequacy and quality assurance and procedures for ensuring compliance with those standards; and

(b) if appropriate, initiate action against a health carrier whose managed care plan does not comply with standards for network adequacy and quality assurance adopted by the commissioner.

(2) Quality assurance standards adopted by the commissioner must consist of some but not all of the health plan employer data and information standards. The commissioner shall select and adopt only standards appropriate for quality assurance in Montana.

(3) The state may contract, through a competitive bidding process, for the development of network adequacy and quality assurance standards.

History: En. Sec. 12, Ch. 413, L. 1997; amd. Sec. 40, Ch. 157, L. 2023.

Part 2
Network Adequacy

33-36-201. Network adequacy — standards — access plan required. (1) A health carrier offering a managed care plan in this state shall maintain a network that is sufficient in numbers and types of providers to ensure that all services to covered persons are accessible without unreasonable delay. Sufficiency in number and type of provider is determined in accordance with the requirements of this section. Covered persons must have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria may include but are not limited to:

(a) a ratio of specialty care providers to covered persons;

(b) a ratio of primary care providers to covered persons;

(c) geographic accessibility;

(d) waiting times for appointments with participating providers;

(e) hours of operation; or

(f) the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(2) Whenever a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers or shall make other arrangements acceptable to the commissioner.

(3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable proximity of participating providers to the businesses or personal residences of covered persons. In determining whether a health carrier has complied with this requirement, consideration must be given to the relative availability of health care providers in the service area under consideration.

(4) A health carrier offering a managed care plan in this state on January 1, 2024, shall file with the commissioner on December 1, 2023, an access plan complying with subsection (6) and the rules of the commissioner. A health carrier offering a managed care plan in this state for the first time after January 1, 2024, shall file with the commissioner an access plan meeting the requirements of subsection (6) and the rules of the commissioner at least 60 days before offering the managed care plan. A plan must be filed with the commissioner in a manner and form complying with the rules of the commissioner. A health carrier shall file any subsequent material changes in its access plan with the commissioner at least 30 days prior to implementation of the change.

(5) A health carrier may request the commissioner to designate parts of its access plan as proprietary or competitive information, and when designated, that part may not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. A health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide a copy of the plan upon request.

(6) An access plan for each managed care plan offered in this state must describe or contain at least the following:

(a) a listing of the names and specialties of the health carrier's participating providers;

(b) the health carrier's procedures for making referrals within and outside its network;

(c) the health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in the managed care plan;

(d) the health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(e) the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(f) the health carrier's method of informing covered persons of the plan's services and features, including but not limited to the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(g) the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians and for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) the health carrier's process for enabling covered persons to change primary care professionals;

(i) the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and a participating provider or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and be transferred to other providers in a timely manner.

(j) any other information required by the commissioner to determine compliance with this part and the rules implementing this part.

(7) The commissioner shall ensure timely and expedited review and approval of the access plan and other requirements in this section.

History: **En. Sec. 13, Ch. 413, L. 1997; amd. Sec. 10, Ch. 325, L. 2003; amd. Sec. 41, Ch. 157, L. 2023.**

33-36-202. Provider responsibility for care — contracts — prohibited collection practices. (1) A contract between a health carrier and a participating provider must set forth a hold harmless provision specifying protection for covered persons. This requirement is met by including in a contract a provision substantially the same as the following:

"The provider agrees that the provider may not for any reason, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a covered person or a person other than the health carrier or intermediary acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person. This agreement does not prohibit a provider, except a health care professional who is employed full-time on the staff of a health carrier and who has agreed to provide services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person if the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in this agreement, this agreement does not prohibit the provider from pursuing any legal remedy available for obtaining payment for services from the health carrier."

(2) A contract between a health carrier and a participating provider must state that if a health carrier or intermediary becomes insolvent or otherwise ceases operations, covered benefits to covered persons will continue through the end of the period for which a premium has been paid to the health carrier on behalf of the covered person, but not to exceed 30 days, or until the covered person's discharge from an acute care inpatient facility, whichever occurs last. Covered benefits to a covered person confined in an acute care inpatient facility on the date of insolvency or other cessation of operations must be continued by a provider until the confinement in an inpatient facility is no longer medically necessary.

(3) The contract provisions that satisfy the requirements of subsections (1) and (2) must be construed in favor of the covered person, survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and supersede an oral or written contrary agreement between a participating provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by subsections (1) and (2).

(4) A participating provider may not collect or attempt to collect from a covered person money owed to the provider by the health carrier.

History: **En. Sec. 14, Ch. 413, L. 1997.**

33-36-203. Selection of providers — professional credentials standards. (1) A health carrier shall adopt standards for selecting participating providers who are primary care professionals and for each health care professional specialty within the health carrier's network. The health carrier shall use the standards to select health care professionals, the health carrier's intermediaries, and any provider network with which the health carrier contracts. A health carrier may not adopt selection criteria that allow the health carrier to:

(a) avoid high-risk populations by excluding a provider because the provider is located in a geographic area that contains populations or providers presenting a risk of higher than average claims, losses, or use of health care services; or

(b) exclude a provider because the provider treats or specializes in treating populations presenting a risk of higher than average claims, losses, or use of health care services.

(2) Subsection (1) does not prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier adopted in compliance with this part and the rules implementing this part.

(3) This part does not require a health carrier, its intermediary, or a provider network with which the health carrier or its intermediary contract to employ specific providers or types of providers who may meet their selection criteria or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

(4) A health carrier may use criteria established in accordance with the provisions of this section to select health care professionals allowed to participate in the health carrier's managed care plan. A health carrier shall make its selection standards for participating providers available for review by the commissioner and by each health care professional who is subject to the selection standards.

History: **En. Sec. 15, Ch. 413, L. 1997; amd. Sec. 42, Ch. 157, L. 2023.**

33-36-204. Health carriers — general responsibilities. (1) A health carrier offering a managed care plan shall notify, in writing, prospective participating providers of the participating providers' responsibilities concerning the health carrier's administrative policies and programs, including but not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and applicable federal or state requirements.

(2) A health carrier may not offer an inducement under a managed care plan to a participating provider to provide less than medically necessary services to a covered person.

(3) A health carrier may not prohibit a participating provider from discussing a treatment option with a covered person or from advocating on behalf of a covered person within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

(4) A health carrier shall require a participating provider to make health records available to appropriate state and federal authorities, in accordance with the applicable state and federal laws related to the confidentiality of medical or health records, when the authorities are involved in assessing the quality of care or investigating a grievance or complaint of a covered person.

(5) A health carrier and participating provider shall provide at least 60 days' written notice to each other before terminating the contract between them without cause. The health carrier shall make a good faith effort to provide written notice of a termination, within 15 working days of receipt or issuance of a notice of termination from or to a participating provider, to all covered persons who are patients seen on a regular basis by the participating provider whose contract is terminating, irrespective of whether the termination is for cause or without cause. If a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional must be notified.

(6) A health carrier shall ensure that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser or as a participant in a publicly financed program of health care services. This requirement does not apply to circumstances in which the participating provider should not render services because of the participating provider's lack of training, experience, or skill or because of a restriction on the participating provider's license.

(7) A health carrier shall notify the participating providers of their obligation, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage or of the participating providers' obligations, if any, to notify covered persons of the covered persons' personal financial obligations for noncovered benefits.

(8) A health carrier may not penalize a participating provider because the participating provider, in good faith, reports to state or federal authorities an act or practice by the health carrier that may adversely affect patient health or welfare.

(9) A health carrier shall establish a mechanism by which a participating provider may determine in a timely manner whether or not a person is covered by the health carrier.

(10) A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between the health carrier and participating providers.

(11) A contract between a health carrier and a participating provider may not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this chapter.

(12) A contract between a health carrier and a participating provider shall set forth all of the responsibilities and obligations of the provider either in the contract or documents referenced in the contract. A health carrier shall make its best effort to furnish copies of any reference documents, if requested by a participating provider, prior to execution of the contract.

History: **En. Sec. 16, Ch. 413, L. 1997.**

33-36-205. Emergency services. (1) A health carrier offering a managed care plan shall provide or pay for emergency services screening and emergency services and may not require prior authorization for either of those services. If an emergency services screening determines that emergency services or emergency services of a particular type are unnecessary for a covered person, emergency services or emergency services of the type determined unnecessary by the screening need not be covered by the health carrier unless otherwise covered under the health benefit plan. However, if screening determines that emergency services or emergency services of a particular type are necessary, those services must be covered by the health carrier. A health carrier shall cover emergency services if the health carrier, acting through a participating provider or other authorized representative, has authorized the provision of emergency services.

(2) A health carrier shall provide or pay for emergency services obtained from a nonnetwork provider within the service area of a managed care plan and may not require prior authorization of those services if use of a participating provider would result in a delay that would worsen the medical condition of the covered person or if a provision of federal, state, or local law requires the use of a specific provider.

(3) If a participating provider or other authorized representative of a health carrier authorizes emergency services, the health carrier may not subsequently retract its authorization after the emergency services have been provided or reduce payment for an item or health care services furnished in reliance on approval unless the approval was based on a material misrepresentation about the covered person's medical condition made by the provider of emergency services.

(4) Coverage of emergency services is subject to applicable coinsurance, copayments, and deductibles.

(5) For postevaluation or poststabilization services required immediately after receipt of emergency services, a health carrier shall provide access to an authorized representative 24 hours a day, 7 days a week, to facilitate review.

History: En. Sec. 17, Ch. 413, L. 1997; amd. Sec. 11, Ch. 325, L. 2003.

33-36-206 through 33-36-208 reserved.

33-36-209. Use of intermediaries — responsibilities of health carriers, intermediaries, and providers. (1) A health carrier is responsible for complying with applicable provisions of this chapter and contracting with an intermediary for all or some of the services for which a health carrier is responsible does not relieve the health carrier of responsibility for compliance.

(2) A health carrier may determine whether a subcontracted provider participates in the provider's own network or a contracted network for the purpose of providing covered benefits to the health carrier's covered persons.

(3) A health carrier shall maintain copies of all intermediary health care subcontracts at the health carrier's principal place of business in this state or ensure that the health carrier has access to all intermediary subcontracts, including the right to make copies of the contracts, upon 20 days' prior written notice from the health carrier.

(4) If required in a contract or otherwise by a health carrier, an intermediary shall transmit utilization documentation and claims-paid documentation to the health carrier. The health carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons. This duty may not be delegated to an intermediary by a health carrier.

(5) If required in a contract or otherwise by a health carrier, an intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons at its principal place of business in the state and preserve them for 5 years in a manner that facilitates regulatory review.

(6) An intermediary shall allow the commissioner access to the intermediary's books, records, claim information, billing information, and other documentation of services provided to covered persons that are required by any of those entities to determine compliance with this part and the rules implementing this part.

(7) A health carrier may, in the event of the intermediary's insolvency, require the assignment to the health carrier of the provisions of a participating provider's contract addressing the participating provider's obligation to furnish covered benefits.

History: **En. Sec. 18, Ch. 413, L. 1997; amd. Sec. 43, Ch. 157, L. 2023.**

33-36-210. Contract filing requirements — material changes — state access to contracts. (1) A health carrier offering a managed care plan in this state on January 1, 2024, shall file with the commissioner on December 1, 2023, sample contract forms proposed for use with its participating providers and intermediaries. A health carrier offering a managed care plan in this state for the first time after January 1, 2024, shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries at least 60 days before offering the managed care plan.

(2) A health carrier shall file with the commissioner a material change to a contract. The change must be filed with the commissioner at least 60 days before use of the proposed change. A change in a participating provider payment rate, coinsurance, copayment, or deductible or other plan benefit is not considered a material change for the purpose of this subsection.

(3) A health carrier shall maintain participating provider and intermediary contracts at its principal place of business in this state, or the health carrier must have access to all contracts and provide copies to the commissioner on 20 days' prior written notice from the commissioner.

History: **En. Sec. 19, Ch. 413, L. 1997; amd. Sec. 44, Ch. 157, L. 2023.**

33-36-211. General contracting requirements. (1) The execution of a contract for health care services with an intermediary by a health carrier does not relieve the health carrier of its duty to provide health care services to a person with whom the health carrier has contracted and does not relieve the health carrier of its responsibility for compliance with this chapter or the rules implementing this chapter.

(2) All contracts by a health carrier for the provision of health care services by a managed care plan must be in writing and are subject to review by the commissioner.

History: **En. Sec. 20, Ch. 413, L. 1997; amd. Sec. 45, Ch. 157, L. 2023.**

33-36-212. Contract compliance dates. A contract between a health carrier and a participating provider or intermediary must comply with this part and the rules implementing this part on the date the contract is issued or put into effect.

History: **En. Sec. 21, Ch. 413, L. 1997; amd. Sec. 46, Ch. 157, L. 2023.**

33-36-213. Rulemaking authority. The commissioner may adopt rules to implement this part.

History: **En. Sec. 22, Ch. 413, L. 1997; amd. Sec. 47, Ch. 157, L. 2023.**

Part 3
Quality Assurance

33-36-301. Quality assurance — national accreditation. (1) A health carrier whose managed care plan has been accredited by a nationally recognized accrediting organization shall annually provide a copy of the accreditation and the accrediting standards used by the accrediting organization to the commissioner.

(2) If the commissioner finds that the standards of a nationally recognized accrediting organization meet or exceed state standards and that the health carrier has been accredited by the nationally recognized accrediting organization, the commissioner shall approve the quality assurance standards of the health carrier.

(3) The commissioner shall maintain a list of accrediting organizations whose standards have been determined by the commissioner to meet or exceed state quality assurance standards.

(4) Section 33-36-302 does not apply to a health carrier's managed care plan if the health carrier maintains current accreditation by a nationally recognized accrediting organization whose standards meet or exceed state quality assurance standards adopted pursuant to this part.

(5) This section does not prevent the commissioner from monitoring a health carrier's compliance with this part.

History: **En. Sec. 23, Ch. 413, L. 1997; amd. Sec. 48, Ch. 157, L. 2023.**

33-36-302. Standards for health carrier quality assessment programs. A health carrier that issues a closed plan or a combination plan shall adopt and use infrastructure and disclosure systems sufficient to accurately measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by the health carrier. To comply with this requirement, a health carrier shall:

(1) establish and use a system designed to assess the quality of health care provided to covered persons and appropriate to the types of plans offered by the health carrier. The system must include systematic collection, analysis, and reporting of relevant data.

(2) communicate in a timely fashion its findings concerning the quality of health care to regulatory agencies, providers, and consumers as provided in 33-36-304;

(3) report to the appropriate professional or occupational licensing board provided in Title 37 any persistent pattern of problematic care provided by a participating provider that is sufficient to cause the health carrier to terminate or suspend a contractual arrangement with the participating provider; and

(4) file a written description of the quality assessment program and any subsequent material changes with the commissioner in a format that must be prescribed by rules of the commissioner. The description must include a signed certification by a corporate officer of the health carrier that the health carrier's quality assessment program meets the requirements of this part.

History: En. Sec. 24, Ch. 413, L. 1997; amd. Sec. 49, Ch. 157, L. 2023.

33-36-303. Standards for health carrier quality improvement programs. A health carrier that issues a closed plan or a combination plan shall, in addition to complying with 33-36-302, adopt and use systems and methods necessary to improve the quality of health care provided in the health carrier's managed care plan as indicated by the health carrier's quality assessment program and as required by this section. To comply with this requirement, a health carrier subject to this section shall:

(1) establish an internal system capable of identifying opportunities to improve care;

(2) use the findings generated by the system required by subsection (1) to work on a continuing basis with participating providers and other staff within the closed plan or closed component to improve the health care delivered to covered persons; and

(3) consistent with this part, adopt and use a program for measuring, assessing and improving the outcomes of health care as identified in the health carrier's quality improvement program plan and provide at the commissioner's request a current quality improvement program plan. The quality improvement program plan must:

(a) implement improvement strategies in response to quality assessment findings that indicate improvement is needed; and

(b) evaluate, not less than annually, the effectiveness of the strategies implemented pursuant to subsection (3)(a).

History: En. Sec. 25, Ch. 413, L. 1997; amd. Sec. 50, Ch. 157, L. 2023.

33-36-304. Reporting and disclosure requirements. (1) A health carrier offering a closed plan or a combination plan shall document and communicate information, as required in this section, about its quality assurance program. The health carrier shall:

(a) include a summary of its quality assurance program in marketing materials;

(b) include a description of its quality assurance program and a statement of patient rights and responsibilities with respect to that program in the certificate of coverage or handbook provided to newly enrolled covered persons; and

(c) make available annually to providers and covered persons a report containing findings from its quality assurance program and information about its progress in meeting internal goals and external standards, when available.

(2) A health carrier shall certify to the commissioner annually that its quality assurance program and the materials provided to providers and consumers in accordance with subsection (1) meet the requirements of this part.

(3) A health carrier shall make available, upon request and payment of a reasonable fee, the materials certified pursuant to subsection (2), except for the materials subject to the confidentiality requirements of 33-36-305 and materials that are proprietary to the managed

care plan. A health carrier shall retain all certified materials for at least 3 years from the date that the material was certified or until the material has been examined as part of a market conduct examination, whichever is later.

History: **En. Sec. 26, Ch. 413, L. 1997; amd. Sec. 51, Ch. 157, L. 2023.**

33-36-305. Confidentiality of health care and quality assurance records — disclosure. (1) Except as provided in subsection (2), the following information held by a health carrier offering a closed plan or a combination plan is confidential and may not be disclosed by the carrier to a person:

(a) information pertaining to the diagnosis, treatment, or health of a covered person, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form;

(b) information considered by a quality assurance program and the records of its actions, including testimony of a member of a quality committee, of an officer, director, or other member of a health carrier or its staff engaged in assisting the quality committee or engaged in the health carrier's quality assessment, quality improvement, or quality assurance activities, or of any person assisting or furnishing information to the quality committee.

(2) The information specified in subsection (1) may be disclosed:

(a) as allowed by Title 33, chapter 19;

(b) as required in proceedings before the commissioner, a professional or occupational licensing board provided in Title 37, or the department of public health and human services pursuant to Title 50, chapter 5, part 2;

(c) in an appeal, if an appeal is permitted, from a quality committee's findings or recommendations; or

(d) as otherwise required by law or court order, including a judicial or administrative subpoena.

(3) Information specified in subsection (1) identifying:

(a) the provider may also be disclosed upon a written, dated, and signed approval of the provider if the information does not identify the covered person;

(b) the covered person may also be disclosed upon a written, dated, and signed approval of the covered person or of the parent or guardian of a covered person if the covered person is a minor and if the information does not identify the provider;

(c) neither the provider nor the covered person may also be disclosed upon request for use for statistical purposes only.

History: **En. Sec. 27, Ch. 413, L. 1997; amd. Sec. 52, Ch. 157, L. 2023.**

Cross-References

Right of privacy, Art. II, sec. 10, Mont. Const.
Uniform Health Care Information Act, Title 50, ch. 16, part 5.
Government Health Care Information Act, Title 50, ch. 16, part 6.

Part 4
Enforcement

33-36-401. Enforcement. (1) If the commissioner determines that a health carrier has not complied with this chapter or the rules implementing this chapter, the commissioner may recommend corrective action to the health carrier.

(2) The commissioner may take an enforcement action provided in subsection (3) if:

(a) a health carrier fails to implement corrective action recommended by the commissioner;

(b) corrective action taken by a health carrier does not result in bringing a health carrier into compliance with this chapter and the rules implementing this chapter within a reasonable period of time;

(c) a health carrier does not comply with this chapter or the rules implementing this chapter; or

(d) the commissioner determines that a health carrier has violated or is violating this chapter or the rules implementing this chapter.

(3) The commissioner may take any of the following enforcement actions to require a health carrier to comply with this chapter or the rules implementing this chapter:

(a) suspend or revoke the health carrier's certificate of authority or deny the health carrier's application for a certificate of authority; or

(b) use any of the commissioner's other enforcement powers provided in Title 33, chapter 1, part 3.

History: **En. Sec. 28, Ch. 413, L. 1997; amd. Sec. 53, Ch. 157, L. 2023.**

33-36-402. Jurisdiction over contract actions. The district courts have jurisdiction over actions for the enforcement of contracts authorized or regulated by this chapter.

History: **En. Sec. 29, Ch. 413, L. 1997.**

CHAPTER 37

REGULATION OF HEALTH CARRIERS AND MANAGED CARE ENTITIES

(Repealed)

Part 1 — General Provisions (Repealed)

Part 1

General Provisions

(Repealed)

33-37-101. Repealed. Sec. 40, Ch. 428, L. 2015.

History: **En. Sec. 1, Ch. 482, L. 1999.**

33-37-102. Repealed. Sec. 40, Ch. 428, L. 2015.

History: **En. Sec. 2, Ch. 482, L. 1999.**

33-37-103. Repealed. Sec. 40, Ch. 428, L. 2015.

History: **En. Sec. 3, Ch. 482, L. 1999.**

33-37-104. Repealed. Sec. 40, Ch. 428, L. 2015.

History: **En. Sec. 4, Ch. 482, L. 1999.**

33-37-105. Repealed. Sec. 40, Ch. 428, L. 2015.

History: **En. Sec. 5, Ch. 482, L. 1999.**

33-37-106. Repealed. Sec. 40, Ch. 428, L. 2015.

History: **En. Sec. 8, Ch. 482, L. 1999.**

33-37-107 through 33-37-109 reserved.

33-37-110. Repealed. Sec. 40, Ch. 428, L. 2015.

History: **En. Sec. 1, Ch. 107, L. 2001.**

CHAPTER 38

MEDICAL CARE AND PHARMACY DISCOUNT CARDS

Part 1 — General Provisions

33-38-101. Short title — purpose.
33-38-102. Definitions.
33-38-103. Unlawful acts by medical care discount card suppliers or enrollers.
33-38-104. Right to return or cancel medical care discount card or pharmacy discount card — notice — prohibited acts.
33-38-105. Sale of medical care discount card by unregistered supplier prohibited — requirements for registration — list of authorized enrollers required — exceptions.
33-38-106. Medical care discount card supplier financial responsibility requirements — claims against bonds or accounts — exemptions.
33-38-107. Waiver of registration and bonding requirements.
33-38-108. Pharmacy discount card supplier requirements.

Part 1
General Provisions

33-38-101. Short title — purpose. (1) This part may be cited as the "Montana Medical Care Discount Card and Pharmacy Discount Card Act".

(2) The purposes of this part are to regulate the promotion, offer, sale, and use of medical care discount cards and pharmacy discount cards and to facilitate the detection of and reduce the occurrence of medical care discount card and pharmacy discount card fraud.

History: En. Sec. 4, Ch. 456, L. 2005.

33-38-102. Definitions. As used in this part, unless the context indicates otherwise, the following definitions apply:

(1) (a) "Administrator" has the meaning provided for in 33-17-102(3).

(b) The term includes a pharmacy benefit manager as defined in 33-2-2402.

(2) "Enroller" means a person who:

(a) solicits the purchase or renewal of a medical care discount card through that person;

(b) transmits, for consideration, from a supplier to another person or from another person to a supplier a contract or application for a medical care discount card or the renewal of a medical care discount card; or

(c) acts or aids in another manner in the delivery or negotiation of a medical care discount card or the renewal or continuance of a medical care discount card.

(3) "Health care provider" means:

(a) an individual licensed by the department of labor and industry to practice or who holds a temporary permit to practice a branch of the healing arts;

(b) a professional corporation organized pursuant to Title 35, chapter 4, by one or more individuals described in subsection (3)(a);

(c) a Montana limited liability company organized pursuant to Title 35, chapter 8, for the purpose of rendering professional services by individuals described in subsection (3)(a);

(d) a partnership of individuals described in subsection (3)(a);

(e) a Montana nonprofit corporation organized pursuant to Title 35, chapter 2, for the purpose of rendering professional health care services by one or more individuals described in subsection (3)(a); or

(f) a health care facility as defined in 50-5-101.

(4) "Health insurance issuer" means a health insurance issuer, as defined in 33-22-140, that is authorized to do business in this state and its affiliates, as defined in 33-2-1101.

(5) (a) "Medical care discount card" means a paper or plastic device or other mechanism, arrangement, account, or other device that does not constitute insurance, as defined in 33-1-201, that purports to grant, for consideration, a discount or access to a discount in a medical care-related purchase from a health care provider.

(b) The term does not include a pharmacy discount card unless a pharmacy discount benefit is combined with another type of medical care discount.

(6) "Medical care discount card supplier" means a person engaged in selling or furnishing, either as principal or agent, for consideration, one or more medical care discount cards to another person or persons.

(7) "Network of health care providers" means two or more health care providers who are contractually obligated to provide services in accordance with the terms and conditions applicable to a medical care discount card.

(8) "Pharmacy discount card" means a paper or plastic device or other mechanism, arrangement, account, or other device that does not constitute insurance, as defined in 33-1-201, that purports to grant, for consideration, a discount or access to a discount on one or more prescription drugs, and that is not combined with another type of medical care discount.

(9) "Pharmacy discount card supplier" means a person engaged in selling or furnishing, either as a principal or agent, for consideration, one or more pharmacy discount cards to another person or persons.

(10) "Preferred provider organization company" means a company that contracts with health care providers for lower fees than those customarily charged by the health care provider for services and contracts with health insurance issuers, administrators, or self-insured

employers to provide access to those lower fees to a particular group of insureds, subscribers, participants, beneficiaries, members, or claimants.

(11) "Prescription drug provider" means a pharmacy or other business that is contractually bound to provide a discount on one or more prescription drugs in conjunction with the use of a pharmacy discount card.

(12) "Service area" means the area within a 60-mile radius of the home or place of business of a medical care discount card user or pharmacy discount card user.

History: En. Sec. 5, Ch. 456, L. 2005; amd. Sec. 20, Ch. 501, L. 2021.

33-38-103. Unlawful acts by medical care discount card suppliers or enrollers. (1) A medical care discount card supplier or an enroller that markets, promotes, advertises, or distributes a medical care discount card in Montana:

(a) may not make misleading, deceptive, or fraudulent representations regarding:

(i) the discount or range of discounts offered by a medical care discount card;

(ii) the access to any range of discounts offered by a medical care discount card; or

(iii) another medical care service provided in connection with a medical care discount card;

(b) may not use terms or phrases commonly associated with insurance products that could lead a prospective purchaser or user of a medical care discount card to believe that the card being offered is composed of one or more insurance products or is a substitute for insurance, despite disclaimers to the contrary by the medical care discount card supplier or enroller;

(c) shall provide to a prospective purchaser or user, before purchase, access to a list of health care providers, including the name, city, state, and provider type and, optionally, the address and telephone number of each health care provider in the prospective purchaser's or user's service area; and

(d) shall make continuously available to each medical care discount card user, through a toll-free telephone number, the internet, and in writing upon request, the name, address, telephone number, and provider type of all health care providers in the user's service area who are bound by contract to provide services in accordance with the terms and conditions applicable to the card.

(2) A medical care discount card supplier that markets, promotes, advertises, or distributes a medical care discount card in Montana shall:

(a) state, on all advertisements for medical care discount cards, in bold and prominent type of at least 14 points in size, and on all cards themselves in clear and conspicuous type, that the card is not insurance;

(b) designate and provide the commissioner with the name, address, and telephone number of a medical care discount card compliance officer responsible for ensuring compliance with the provisions of this part applicable to medical care discount cards and medical care discount card suppliers and enrollers; and

(c) ensure that if the medical care discount card supplier claims that a specific health care provider offers a discount in conjunction with the medical care discount card, that specific health care provider is contractually bound to provide that discount to the purchaser or user.

History: En. Sec. 6, Ch. 456, L. 2005.

33-38-104. Right to return or cancel medical care discount card or pharmacy discount card — notice — prohibited acts. (1) A medical care discount card or pharmacy discount card issued for delivery in this state is returnable or cancelable, within 30 days of the date of delivery of the card or a longer period if provided in the purchase agreement, by the purchaser or user for any reason, and the user must receive a full refund of all fees, except nominal fees associated with enrollment costs, that were part of the cost of the card.

(2) A medical care discount card supplier or pharmacy discount card supplier may not charge or collect a fee, including a cancellation fee, after a purchaser or user has returned a card to the supplier or given the supplier notice of the person's intention to return or cancel the card.

(3) A medical care discount card supplier or pharmacy discount card supplier shall ensure that each purchaser or user receives with the card a notice stating the terms under which the medical care discount card or pharmacy discount card may be returned or canceled as provided in subsections (1) and (2). A medical care discount card or pharmacy discount card returned or canceled in accordance with this section is void from the date of purchase.

History: En. Sec. 7, Ch. 456, L. 2005.

33-38-105. Sale of medical care discount card by unregistered supplier prohibited — requirements for registration — list of authorized enrollers required — exceptions. (1) A medical care discount card supplier may not market, promote, sell, or distribute a medical care discount card in this state unless the supplier holds a certificate of registration as a supplier issued by the commissioner.

(2) An application to the commissioner for a certificate of registration must be accompanied by a nonrefundable application fee of $100. The commissioner shall issue the certificate unless the commissioner determines that the medical care discount card supplier or an officer or manager is not financially responsible, does not have adequate expertise or experience to operate a medical care discount card business, or is not of good character or that the supplier or its affiliates or a business formerly owned or managed by the supplier or an officer or manager of the supplier has had a previous application for a certificate of registration denied, revoked, suspended, or terminated for cause or is under investigation for or has been found in violation of a statute or regulation in any jurisdiction within the previous 5 years.

(3) A medical care discount card supplier shall renew its certificate of registration annually by December 31. The certificate is renewed upon payment by the supplier of a nonrefundable renewal fee of $100 and expires on the anniversary of its issuance if the renewal fee is not paid before that date. Once issued or renewed, the certificate continues in effect for 1 year unless suspended, revoked, or terminated. The commissioner shall deposit the fees required by this section with the state treasurer, to be credited to the general fund.

(4) A certificate of registration may be suspended or revoked if, after notice and hearing, the commissioner finds that the medical care discount card supplier has violated a provision of this part, that the supplier is not financially responsible or competent, or that the supplier or an affiliate or business formerly owned or managed by the supplier has had a certificate of registration denied or suspended for cause or has been found in violation of a statute or regulation in another jurisdiction.

(5) A medical care discount card supplier that violates the provisions of subsection (1) is subject to a civil penalty of not less than $5,000 or more than $25,000 for each violation. Each day of violation is considered to be a separate violation.

(6) A medical care discount card supplier that is a health insurance issuer is not required to obtain a certificate of registration in accordance with this section, except that affiliates, as defined in 33-2-1101, that are selling medical care discount cards in Montana shall obtain a certificate of registration.

(7) An administrator that is authorized to do business in this state and that provides medical care discount cards to Montana residents who are members of self-funded group health plans administered by that administrator is not required to obtain a certificate of registration pursuant to this section.

(8) A person commencing business as a medical care discount card supplier shall file a certificate of registration and its list of authorized enrollers with the commissioner at least 30 days before commencing business as a supplier. After the initial filing of a list of its enrollers with the commissioner, a supplier shall file an updated list annually by December 31.

(9) This section does not excuse a medical care discount card supplier that is also an insurer from full compliance with the Montana Insurance Code.

History: En. Sec. 8, Ch. 456, L. 2005; amd. Sec. 27, Ch. 399, L. 2007.

33-38-106. Medical care discount card supplier financial responsibility requirements — claims against bonds or accounts — exemptions. (1) A person intending to act as a medical care discount card supplier may not market, promote, advertise, or distribute a medical care discount card in this state until the person has purchased a bond or established a surety account and filed with the commissioner a copy of a bond or a statement identifying a surety account depository as provided in this section.

(2) A person intending to act as a medical care discount card supplier shall:

(a) purchase and maintain a surety bond in the amount of $50,000 issued by a surety company authorized to do business in this state; or

(b) establish and maintain a surety account in the amount of $50,000 at a federally insured bank, savings and loan association, or federal savings bank located in this state.

(3) A person intending to act as a medical care discount card supplier shall provide the depository, trustee, and account number of the surety account to the commissioner and shall annually provide to the commissioner proof of renewal of the bond or maintenance of the surety account. The person shall pay a nonrefundable filing fee of $250 with the initial filing and with each subsequent filing.

(4) A medical care discount card supplier shall maintain the surety account or bond until 2 years after the date that the supplier ceases operations in the state. Money from a surety account may not be released to the supplier without the written consent of the commissioner.

(5) A surety on a medical care discount card company bond may not cancel a bond required by this section without giving at least 21 days' written notice of cancellation to the medical care discount card supplier and the commissioner. If the commissioner receives notice of a surety's intention to cancel a supplier's bond, the commissioner shall notify the affected supplier that, unless the supplier files another $50,000 surety bond with the commissioner or establishes a $50,000 surety account on or before the date the bond is to be canceled, the supplier may no longer do business as a supplier in this state.

(6) A bond surety shall write a bond required by this section and a person intending to act as a medical care discount card supplier shall establish an account in favor of a person, and the commissioner for the benefit of a person, injured by a violation of this part. The bond surety shall also write the bond to cover any fines levied against the supplier, a supplier's enroller, or both, for a violation of this part occurring during the time the supplier's bond is in effect.

(7) A person with a claim against a medical care discount card supplier's bond or surety account for a violation of a provision of this part may maintain an action against the supplier and against either the bond surety or the trustee of the surety account, as appropriate. The aggregate liability of the surety or trustee to a person injured by a violation of this part may not exceed the amount of the surety bond or account.

(8) A person acting as a medical care discount card supplier on October 1, 2005, shall file with the commissioner a copy of a surety bond or statement identifying a surety account depository on that date. A person commencing business as a supplier after October 1, 2005, shall file a copy of a bond or statement with the commissioner at least 30 days before commencing business as a supplier.

(9) A health insurance issuer that is also a medical care discount card supplier is exempt from the requirements of this section.

(10) An administrator that is authorized to do business in this state and that provides medical care discount cards to Montana residents who are members of self-funded group health plans administered by that administrator is exempt from the requirements of this section.

History: En. Sec. 9, Ch. 456, L. 2005.

33-38-107. Waiver of registration and bonding requirements. The commissioner may waive the requirements of 33-38-105 and 33-38-106 for any preferred provider organization company. The factors taken into account in granting a waiver include but are not limited to whether the company:

(1) has contracts in place with health care providers residing in this state;

(2) has contracts in place with users and purchasers of health care services residing in this state who use the medical care discount card in conjunction with a self-funded or fully insured health plan;

(3) is primarily in the preferred provider organization business or primarily in the medical care discount card supplier business; and

(4) was in business in this state prior to October 1, 2005.

History: En. Sec. 10, Ch. 456, L. 2005.

33-38-108. Pharmacy discount card supplier requirements. (1) A pharmacy discount card supplier that sells, markets, promotes, or distributes, for a consideration, a pharmacy discount card in Montana:

(a) shall clearly and conspicuously disclose on all advertising, marketing materials, and enrollment materials that discounts offered through the use of a pharmacy discount card are not insurance and are not intended as a substitute for insurance;

(b) shall clearly and conspicuously disclose on all pharmacy discount cards that discounts offered through the use of the pharmacy discount card are not insurance;

(c) shall disclose, when a pharmacy discount card is sold in combination with a group limited supplemental insurance policy, that discounts offered through the use of the pharmacy discount card are not insurance;

(d) may not, in the advertising or offering of the pharmacy discount card, use terms or phrases commonly associated only with insurance products that could lead a prospective purchaser or user of the card to believe that the pharmacy discount card is composed of insurance products or is a substitute for insurance, despite disclaimers to the contrary by the pharmacy discount card supplier;

(e) shall ensure that each prescription drug provider claimed by the pharmacy discount card supplier to offer a discount in conjunction with the pharmacy discount card is contractually bound to provide that discount to the purchaser or user;

(f) may not make misleading, deceptive, or fraudulent representations regarding a discount or range of discounts available through the use of a pharmacy discount card;

(g) shall provide to each prospective purchaser or user prior to purchase reasonable access to a list of the benefits and services provided through the use of a pharmacy discount card;

(h) shall provide a prospective purchaser or user prior to purchase access to a list of any prescription drug providers in the prospective purchaser's or user's service area;

(i) shall disclose in all enrollment materials that a pharmacy discount card purchaser or user has 30 days to cancel a pharmacy discount card as provided in 33-38-104;

(j) shall make available to each pharmacy discount card user continuously after purchase of a pharmacy discount card, through a toll-free telephone number, the internet, and in writing upon request, the name, address, and telephone number of each prescription drug provider in the user's service area, including mail order prescription drug providers, that are bound by contract to offer prescription drugs in accordance with the terms and conditions of the pharmacy discount card; and

(k) shall designate and provide the commissioner with the name, address, and telephone number of a pharmacy discount card compliance officer responsible for ensuring compliance with the provisions of this part applicable to pharmacy discount cards and pharmacy discount card suppliers.

(2) A person violating the provisions of subsection (1) is subject to the fine provided for in 33-1-317.

History: **En. Sec. 11, Ch. 456, L. 2005.**

CHAPTER 39
INTERSTATE INSURANCE PRODUCT REGULATION

Part 1 — Interstate Insurance Product Regulation Compact

33-39-101. Compact adopted.
33-39-102. Montana compact commissioner — alternate.
33-39-103. Opt-out duties, guidelines, remedies.

Part 1
Interstate Insurance Product Regulation Compact

33-39-101. Compact adopted. The Interstate Insurance Product Regulation Compact is enacted into law and entered into with all jurisdictions legally joining in the compact, in the form substantially as set forth below.

Article I. Purposes

Pursuant to terms and conditions of this compact, the state of Montana seeks to join with other states and establish the Interstate Insurance Product Regulation Compact. Through means of joint and cooperative action among the compacting states, the purposes of this compact are:

(1) to promote and protect the interest of consumers of individual and group annuity, life insurance, disability income, and long-term care insurance products;
(2) to develop uniform standards for insurance products covered under the compact;
(3) to establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisement related to the products, submitted by insurers authorized to do business in one or more compacting states;
(4) to give appropriate regulatory approval to those product filings and advertisement satisfying the applicable uniform standard;
(5) to improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;
(6) to create the interstate insurance product regulation commission; and
(7) to perform these and other related functions as may be consistent with the state regulation of the business of insurance.

Article II. Definitions

For purposes of this compact, the following definitions apply:
(1) "Advertisement" means any material designed to create public interest in a product or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace, or retain a policy, as more specifically defined in the rules and operating procedures of the commission.
(2) "Bylaws" mean those bylaws established by the commission for its governance or for directing or controlling the commission's actions or conduct.
(3) "Compacting state" means a state that has enacted this compact legislation and that has not withdrawn pursuant to Article XIV, subsection (1), or been terminated pursuant to Article XIV, subsection (2).
(4) "Commission" means the interstate insurance product regulation commission established by this compact.
(5) "Commissioner" means the chief insurance regulatory official of a state, including but not limited to a commissioner, superintendent, director, or administrator.
(6) "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry.
(7) "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this compact.
(8) "Member" means the person chosen by a compacting state as its representative to the commission or the designee named by the representative to the commission.
(9) "Noncompacting state" means a state that is not at the time a compacting state.
(10) "Operating procedures" mean procedures promulgated by the commission implementing a rule, a uniform standard, or a provision of this compact.
(11) "Product" means the form of a policy or contract, including any application, endorsement, or related form that is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an insurer is authorized to issue.
(12) "Rule" means a statement of general or particular applicability and future effect promulgated by the commission, including a uniform standard developed pursuant to Article VII, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the commission, which has the force of law in the compacting states.
(13) "State" means any state, district, or territory of the United States of America.
(14) "Third-party filer" means an entity that submits a product filing to the commission on behalf of an insurer.
(15) "Uniform standard" means a standard adopted by the commission for a product line pursuant to Article VII and includes all of the product requirements in aggregate, provided that each uniform standard must be construed, whether express or implied, to prohibit the use of any inconsistent, misleading, or ambiguous provisions in a product and the form of the product made available to the public may not be unfair, inequitable, or against public policy as determined by the commission.

Article III. Establishment of the Commission and Venue

(1) The compacting states create and establish a joint public agency known as the interstate insurance product regulation commission. Pursuant to Article IV, the commission has the power to develop uniform standards for product lines, receive and provide prompt review of products filed with the commission, and give approval to those product filings satisfying applicable uniform standards. However, it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. Nothing in the compact prohibits any insurer from filing its product in any state in which the insurer is licensed to conduct the business of insurance, and any such filing is subject to the laws of the state where filed.

(2) The commission is a body corporate and politic and an instrumentality of the compacting states.

(3) The commission is solely responsible for its liabilities except as otherwise specifically provided in this compact.

(4) Venue is proper and judicial proceedings by or against the commission must be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located.

Article IV. Powers of the Commission

The commission has the following powers:

(1) to promulgate rules, pursuant to Article VII, which have the force of law and are binding in the compacting states to the extent and in the manner provided in this compact;

(2) to exercise its rulemaking authority and establish reasonable uniform standards for products covered under the compact and advertisement related to the products, which have the force of law and are binding in the compacting states, but only for those products filed with the commission, provided that a compacting state has the right to opt out of the uniform standard pursuant to Article VII, to the extent and in the manner provided in this compact, and provided further that any uniform standard established by the commission for long-term care insurance products may provide the same or greater protections for consumers as, but may not provide less than, those protections set forth in the national association of insurance commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the national association of insurance commissioners' Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the national association of insurance commissioners require amending of the uniform standards established by the commission for long-term care insurance products.

(3) to receive and review in an expeditious manner products filed with the commission and rate filings for disability income and long-term care insurance products and to give approval of those products and rate filings that satisfy the applicable uniform standard, where the approval has the force of law and is binding on the compacting states to the extent and in the manner provided in the compact;

(4) to receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the commission and to give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long-term care insurance products, the commission has the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of the commission as provided in this section have the force of law and are binding in the compacting states to the extent and in the manner provided in the compact.

(5) to exercise its rulemaking authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the commission;

(6) to promulgate operating procedures pursuant to Article VII that are binding in the compacting states to the extent and in the manner provided in this compact;

(7) to bring and prosecute legal proceedings or actions in its name as the commission, provided that the standing of any state insurance department to sue or be sued under applicable law may not be affected;

(8) to issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(9) to establish and maintain offices;

(10) to purchase and maintain insurance and bonds;

(11) to borrow, accept, or contract for services of personnel, including but not limited to employees of a compacting state;

(12) to hire employees, professionals, or specialists and elect or appoint officers, to fix their compensation, define their duties, give them appropriate authority to carry out the purposes of the compact, and determine their qualifications, and to establish the commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation, and qualifications of personnel;

(13) to accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the commission shall strive to avoid any appearance of impropriety;

(14) to lease, purchase, or accept appropriate gifts or donations of or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the commission shall strive to avoid any appearance of impropriety;

(15) to sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property whether real, personal, or mixed;

(16) to remit filing fees to compacting states as may be set forth in the bylaws, rules, or operating procedures;

(17) to enforce compliance by compacting states with rules, uniform standards, operating procedures, and bylaws;

(18) to provide for dispute resolution among compacting states;

(19) to advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this compact;

(20) to provide advice and training to those personnel in state insurance departments responsible for product review and to be a resource for state insurance departments;

(21) to establish a budget and make expenditures;

(22) to borrow money;

(23) to appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and other interested persons as may be designated in the bylaws;

(24) to provide and receive information from and to cooperate with law enforcement agencies;

(25) to adopt and use a corporate seal; and

(26) to perform other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of the business of insurance.

Article V. Organization of the Commission

(1) Membership, voting, and bylaws.

(a) Each compacting state has and is limited to one member. Each member must be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which the member is appointed. Any vacancy occurring in the commission must be filled in accordance with the laws of the compacting state in which the vacancy exists. Nothing in the compact may be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner.

(b) Each member is entitled to one vote and must have an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision in the compact to the contrary, an action of the commission with respect to the promulgation of a uniform standard may not be effective unless two-thirds of the members vote in favor of the standard.

(c) The commission shall, by a majority vote of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including but not limited to:

(i) establishing the fiscal year of the commission;

(ii) providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee;

(iii) providing reasonable standards and procedures:

(A) for the establishment and meetings of other committees; and

(B) governing any general or specific delegation of any authority or function of the commission;

(iv) providing reasonable procedures for calling and conducting meetings of the commission that consist of a majority of commission members, ensuring reasonable advance notice of each meeting, and providing for the right of citizens to attend each meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting in whole or in part. As soon as practicable, the commission shall make public:

(A) a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed; and

(B) votes taken during the meeting.

(v) establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the commission;

(vi) providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws must exclusively govern the personnel policies and programs of the commission.

(vii) promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

(viii) providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment or reserving of all of its debts and obligations.

(d) The commission shall publish its bylaws in a convenient form and file a copy of the bylaws and a copy of any amendment to the bylaws with the appropriate agency or officer in each of the compacting states.

(2) Management committee, officers, and personnel.

(a) A management committee comprising no more than 14 members must be established as follows:

(i) one member from each of the six compacting states with the largest premium volume for individual and group annuities, life, disability income, and long-term care insurance products as determined from the records of the national association of insurance commissioners for the prior year;

(ii) four members from those compacting states with at least 2% of the market based on the premium volume described in subsection (2)(a)(i), other than the six compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

(iii) four members from those compacting states with less than 2% of the market, based on the premium volume described in subsection (2)(a)(i), with one selected from each of the four zone regions of the national association of insurance commissioners as provided in the bylaws.

(b) The management committee has the authority and duties set forth in the bylaws, including but not limited to:

(i) managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission;

(ii) establishing and overseeing an organizational structure within and appropriate procedures for the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard, provided that a uniform standard may not be submitted to the compacting states for adoption unless approved by two-thirds of the members of the management committee;

(iii) overseeing the offices of the commission; and

(iv) planning, implementing, and coordinating communications and activities with other state, federal, and local government organizations in order to advance the goals of the commission.

(c) The commission shall annually elect officers from the management committee, with each having the authority and duties specified in the bylaws.

(d) The management committee may, subject to the approval of the commission, appoint or retain an executive director for a period, upon the terms and conditions, and for the compensation that the commission considers appropriate. The executive director shall serve as secretary to the commission but may not be a member of the commission. The executive director shall hire and supervise other staff authorized by the commission.

(3) Legislative and advisory committees.

(a) A legislative committee comprising state legislators or their designees must be established to monitor the operations of and make recommendations to the commission, including the management committee, provided that the manner of selection and term of any legislative committee member must be as set forth in the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget, or other significant matter provided in the bylaws, the management committee shall consult with and report to the legislative committee.

(b) The commission shall establish two advisory committees, one comprising consumer representatives independent of the insurance industry and the other comprising insurance industry representatives.

(c) The commission may establish additional advisory committees as its bylaws may provide to carry out its functions.

(4) Corporate records of the commission. The commission shall maintain its corporate books and records in accordance with the bylaws.

(5) Qualified immunity, defense, and indemnification.

(a) The members, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that nothing in this subsection (5)(a) may be construed to protect any person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that nothing in the compact may be construed to prohibit that person from retaining personal counsel and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful and wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities or that the person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful and wanton misconduct of that person.

Article VI. Meetings and Acts of the Commission

(1) The commission shall meet and take actions that are consistent with the provisions of this compact and the bylaws.

(2) Each member of the commission has the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by other means that are provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(3) The commission shall meet at least once during each calendar year. Additional meetings must be held as set forth in the bylaws.

Article VII. Rules and Operating Procedures — Rulemaking Functions of the Commission and Opting Out of Uniform Standards

(1) Rulemaking authority. The commission shall promulgate reasonable rules, including uniform standards, and operating procedures to effectively and efficiently achieve the purposes of this compact. Notwithstanding the foregoing, if the commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this compact or the powers granted by this compact, then the action by the commission is invalid and has no force.

(2) Rulemaking procedure. Rules and operating procedures must be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedures Act of 1981, as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committee or committees in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. In adopting a uniform standard, the commission shall consider fully all submitted materials and issue a concise explanation of its decision.

(3) Effective date and opt out of a uniform standard. A uniform standard becomes effective 90 days after its promulgation by the commission or at a later date determined by the commission, provided, however, that a compacting state may opt out of a uniform standard as provided in this article. "Opt out" means any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures and amendments of the rules and operating procedures become effective as of the date specified in each rule, operating procedure, or amendment.

(4) Opt-out procedure.

(a) A compacting state may opt out of a uniform standard, either by legislation or regulation promulgated by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by regulation, the compacting state shall:

(i) give written notice to the commission no later than 10 business days after the uniform standard is promulgated or at the time the state becomes a compacting state; and

(ii) find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state that warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner shall consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh:

(A) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this compact; and

(B) the presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

(b) Notwithstanding subsection (4)(a), a compacting state may, at the time of its enactment of this compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for the opt out in the enacted compact, and the opt out may not be treated as a material variance in the offer or acceptance of any state to participate in this compact. The opt out is effective at the time of enactment of this compact by the compacting state and applies to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

(5) Effect of opt out.

(a) If a compacting state elects to opt out of a uniform standard, the uniform standard remains applicable in the compacting state electing to opt out until the opt-out legislation is enacted into law or the regulation opting out becomes effective.

(b) Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard has no further force in that state unless the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out has the same prospective effect as provided under Article XIV for withdrawals.

(6) Stay of uniform standard. If a compacting state has formally initiated the process of opting out of a uniform standard by regulation and while the regulatory opt out is pending, the compacting state may petition the commission, at least 15 days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If the commission grants or extends a stay, the stay or extension may postpone the effective date by up to 90 days unless affirmatively extended by the commission, provided that a stay may not be permitted to remain in effect for more than 1 year unless the compacting state can show extraordinary circumstances that warrant a continuance of the stay, including but not limited to the existence of a legal challenge that prevents the compacting state from opting out. The commission may terminate a stay upon notice that the rulemaking process has been terminated.

(7) Not later than 30 days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure, provided that the filing of a petition may not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and may not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.

Article VIII. Commission Records and Enforcement

(1) The commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except information and records involving the privacy of individuals and insurers' trade secrets. The commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure and may enter into agreements with those agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(2) Except with regard to privileged records, data, and information, the laws of any compacting state pertaining to confidentiality or nondisclosure may not relieve any compacting state commissioner of the duty to disclose any relevant records, data, or information to the commission, provided that disclosure to the commission may not be considered to waive or otherwise affect any confidentiality requirement and provided further that, except as otherwise expressly provided in this compact, the commission may not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data, and information in its possession. Confidential information of the commission must remain confidential after the information is provided to any commissioner.

(3) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall notify any noncomplying compacting state in writing of its noncompliance with commission bylaws, rules, or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state is considered to be in default as set forth in Article XIV.

(4) The commissioner of any state in which an insurer is authorized to do business or is conducting the business of insurance shall continue to exercise authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law.

The commissioner's enforcement of compliance with the compact is governed by the following provisions:

(a) With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the commission, the content of the product or advertisement may not constitute a violation of the provisions, standards, or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission.

(b) Before a commissioner may bring an action for violation of any provision, standard, or requirement of the compact relating to the content of an advertisement not approved or certified to the commission, the commission or an authorized commission officer or employee shall authorize the action. However, authorization pursuant to this subsection (4)(b) does not require notice to the insurer, opportunity for hearing, or disclosure of requests for authorization or records of the commission's action on the requests.

Article IX. Dispute Resolution

The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and that may arise between two or more compacting states or between compacting states and noncompacting states, and the commission shall promulgate an operating procedure providing for resolution of the disputes.

Article X. Product Filing and Approval

(1) Insurers and third-party filers seeking to have a product approved by the commission shall file the product with and pay applicable filing fees to the commission. Nothing in this compact may be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state in which the insurer is licensed to conduct the business of insurance, and the filing is subject to the laws of the states where filed.

(2) The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. Notwithstanding any provision in this compact to the contrary, the commission shall promulgate rules to establish conditions and procedures under which the commission shall provide public access to product filing information. In establishing the rules, the commission shall consider the interests of the public in having access to the information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

(3) Any product approved by the commission may be sold or otherwise issued in those compacting states in which the insurer is legally authorized to do business.

Article XI. Review of Commission Decisions Regarding Filings

(1) Not later than 30 days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall promulgate rules to establish procedures for appointing a review panel and provide for notice and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law is subject to judicial review in accordance with Article III, subsection (4).

(2) The commission has authority to monitor, review, and reconsider products and advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant uniform standard. When appropriate, the commission may withdraw or modify its approval after proper notice and hearing subject to the appeal process in subsection (1).

Article XII. Finance

(1) The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the national association of insurance commissioners, compacting states, and other sources. Contributions and other forms of funding

from other sources must be of such a nature that the independence of the commission concerning the performance of its duties may not be compromised.

(2) The commission shall collect a filing fee from each insurer and third-party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

(3) The commission's budget for a fiscal year may not be approved until the budget has been subject to notice and comment as set forth in Article VII.

(4) The commission is exempt from all taxation in and by the compacting states.

(5) The commission may not pledge the credit of any compacting state except by and with the appropriate legal authority of that compacting state.

(6) The commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the commission are subject to the accounting procedures established under the commission bylaws. The financial accounts and reports, including the system of internal controls and procedures of the commission, must be audited annually by an independent certified public accountant. Upon the determination of the commission, but no less frequently than every 3 years, the review of the independent auditor must include a management and performance audit of the commission. The commission shall make an annual report to the governor and legislature of the compacting states, which must include a report of the independent audit. The commission's internal accounts are not confidential, and the materials may be shared with the commissioner of any compacting state upon request. However, any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, must remain confidential.

(7) No compacting state has any claim to or ownership of any property held by or vested in the commission or to any commission funds held pursuant to the provisions of this compact.

Article XIII. Compacting States, Effective Date, and Amendment

(1) Any state is eligible to become a compacting state.

(2) The compact becomes effective and binding upon legislative enactment of the compact into law by two compacting states; however, the commission becomes effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of products filed with the commission that satisfy applicable uniform standards only after 26 states are compacting states or, alternatively, by states representing greater than 40% of the premium volume for life insurance, annuity, disability income, and long-term care insurance products, based on records of the national association of insurance commissioners for the prior year. Thereafter, the compact becomes effective and binding as to any other compacting state upon enactment of the compact into law by the state.

(3) Amendments to the compact may be proposed by the commission for enactment by the compacting states. An amendment does not become effective and binding upon the commission and the compacting states until all compacting states enact the amendment into law.

Article XIV. Withdrawal, Default, and Termination

(1) Withdrawal.

(a) Once effective, the compact continues in force and remains binding upon each compacting state, provided that a compacting state may withdraw from the compact ("withdrawing state") by enacting a statute specifically repealing the statute that enacted the compact into law.

(b) The effective date of withdrawal is the effective date of the repealing statute. The withdrawal may not apply to any product filings approved or self-certified, or any advertisement of those products, on the date the repealing statute becomes effective except by mutual agreement of the commission and the withdrawing state unless the withdrawing state rescinds the approval as provided in subsection (1)(e).

(c) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state.

(d) The commission shall notify the other compacting states of the introduction of the legislation within 10 days after its receipt of notice.

(e) The withdrawing state is responsible for all obligations, duties, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement prior to the effective date of withdrawal continues to be effective and must be given full force in the withdrawing state unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law.

(f) Reinstatement following withdrawal of any compacting state occurs upon the effective date of the withdrawing state reenacting the compact.

(2) Default.

(a) If the commission determines that any compacting state has at any time defaulted ("defaulting state") in the performance of any of its obligations or responsibilities under this compact, the bylaws, or duly promulgated rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges, and benefits conferred by this compact on the defaulting state must be suspended from the effective date of default as fixed by the commission. The grounds for default include but are not limited to failure of a compacting state to perform its obligations or responsibilities and any other grounds designated in the commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state must be terminated from the compact and all rights, privileges, and benefits conferred by this compact must be terminated from the effective date of termination.

(b) Product approvals by the commission, product self-certifications, or any advertisement in connection with the product that is in force on the effective date of termination remains in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to subsection (1) of this article.

(c) Reinstatement following termination of any compacting state requires a reenactment of the compact.

(3) Dissolution of compact.

(a) The compact dissolves effective upon the date of the withdrawal or default of the compacting state that reduces membership in the compact to one compacting state.

(b) Upon the dissolution of this compact, the compact becomes null and void and is of no further force and the business and affairs of the commission must be wound up and any surplus funds must be distributed in accordance with the bylaws.

Article XV. Severability and Construction

(1) The provisions of this compact are severable, and if any phrase, clause, sentence, or provision is considered unenforceable, the remaining provisions of the compact are enforceable.

(2) The provisions of this compact must be liberally construed to effectuate its purposes.

Article XVI. Binding Effect of Compact and Other Laws

(1) Other laws.

(a) Nothing in this compact prevents the enforcement of any other law of a compacting state, except as provided in subsection (1)(b).

(b) For any product approved or certified to the commission, the rules, uniform standards, and any other requirements of the commission constitute the exclusive provisions applicable to the content, approval, and certification of those products. For advertisement that is subject to the commission's authority, any rule, uniform standard, or other requirement of the commission that governs the content of the advertisement constitutes the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the commission may abrogate or restrict:

(i) the access of any person to state courts;

(ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product;

(iii) state law relating to the construction of insurance contracts; or

(iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

(c) All insurance products filed with individual states are subject to the laws of those states.

(2) Binding effect of this compact.

(a) All lawful actions of the commission, including all rules and operating procedures promulgated by the commission, are binding upon the compacting states.

(b) All agreements between the commission and the compacting states are binding in accordance with their terms.

(c) Upon the request of a party to a conflict over the meaning or interpretation of commission actions and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute.

(d) In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by that provision upon the commission are ineffective as to that compacting state and those obligations, duties, powers, or jurisdiction remain in the compacting state and must be exercised by the agency of the compacting state to which those obligations, duties, powers, or jurisdictions are delegated by law in effect at the time this compact becomes effective.

Article XVII. State of Montana Opt Out

In accordance with the provisions of Article VII, subsection (4)(b), the state of Montana opts out of all existing and prospective uniform standards involving long-term care insurance products and all existing uniform standards involving individual disability income insurance products in order to preserve the state's statutory and constitutional requirements governing these insurance products.

History: En. Sec. 1, Ch. 360, L. 2013.

33-39-102. Montana compact commissioner — alternate. The commissioner of insurance provided for in 2-15-1903 or the commissioner's designated alternate shall represent this state on the interstate insurance product regulation commission.

History: En. Sec. 2, Ch. 360, L. 2013.

33-39-103. Opt-out duties, guidelines, remedies. (1) As a participant in the Interstate Insurance Product Regulation Compact, the commissioner may opt out of any uniform standard that provides a materially lower level of protection for or materially diminishes the rights of Montana policyholders or policy applicants under Montana law.

(2) Using the time periods provided in Title 2, chapter 4, for adopting administrative procedures and prior to notifying the interstate insurance product regulation commission of a decision to opt out, the commissioner shall provide public notice and hold a public hearing to allow for comments on the decision to opt out.

(3) After taking public comment, the commissioner shall notify the interstate insurance product regulation commission, the governor, and the legislative council of the decision to opt out.

(4) A decision of the commissioner to opt out of a uniform standard may be appealed as provided in 33-1-711.

History: En. Sec. 3, Ch. 360, L. 2013.

CHAPTER 40
PATIENT-CENTERED MEDICAL HOMES
(Terminated)

Part 1 — Patient-Centered Medical Homes Act (Terminated)

Part 1
Patient-Centered Medical Homes Act
(Terminated)

33-40-101. Terminated. Sec. 14, Ch. 363, L. 2013.

History: En. Sec. 1, Ch. 363, L. 2013.

33-40-102. Terminated. Sec. 14, Ch. 363, L. 2013.

History: En. Sec. 2, Ch. 363, L. 2013.

33-40-103. Terminated. Sec. 14, Ch. 363, L. 2013.

History: En. Sec. 3, Ch. 363, L. 2013.

33-40-104. Terminated. Sec. 14, Ch. 363, L. 2013.

History: En. Sec. 4, Ch. 363, L. 2013.

33-40-105. Terminated. Sec. 14, Ch. 363, L. 2013.

History: En. Sec. 5, Ch. 363, L. 2013.

TITLE 34

RESERVED